South Tees Hospitals NHS Foundation Trust

Friarage Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Good
Medical care	Good
Surgery	Good
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Friarage Hospital was one of two acute hospitals forming South Tees Hospitals NHS Foundation Trust. The trust provided acute hospital services to the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland. The trust also provided a range of specialist regional services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria. It had a purpose-built academic centre with medical students and nursing and midwifery students undertaking their clinical placements on-site. In total, the trust had 1,351 beds across two hospitals and community, and employed around 9,000 staff. The Friarage Hospital had 170 beds.

The Friarage Hospital provided medical, surgical, critical care, maternity, children and young people's services for people across the Hambleton and Richmondshire area. The hospital also provided urgent and emergency services (A&E) and outpatient services.

We inspected the Friarage Hospital as part of the comprehensive inspection of South Tees Hospitals NHS Foundation Trust, which includes this hospital, James Cook University Hospital and community services. We inspected the Friarage Hospital on 11 December 2014.

Overall, we rated the Friarage Hospital as 'requires improvement'. We rated it 'good' for being caring and well-led, but it requires improvement in providing safe, effective and responsive care.

We rated surgical services, critical care, maternity care, services for young people, and outpatient services as 'good', with A&E, medical care and end of life care as 'requiring improvement'.

Our key findings were as follows:

- Arrangements were in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found that all areas we visited were visibly clean. Infection rates of Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. difficile) were within an expected range for the size of the trust.
- Patients were able to access suitable nutrition and hydration, including special diets. Patients reported that, on the whole, they were content with the quality and quantity of food.
- Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs.
- There was effective communication and collaboration between multidisciplinary teams.
- There were staff shortages, mainly due to vacancies for nursing staff. The trust was actively recruiting following a review of nursing establishments. In the meantime, bank staff overtime and locum staff were being used to fill any deficits in staff numbers.
- The composite of the Hospital Standardised Mortality Ratio (HSMR) indicators was slightly higher than the national average in this trust. The Summary Hospital-level Mortality Indicator (SHMI) was as expected.

We saw several areas of outstanding practice including:

- A team of therapeutic volunteers had been created which was led by a therapeutic nursing sister who had been in place for 18 months. The volunteers had mandatory and dementia training and were in operation 24hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The team had been regionally recognised for its work.

Summary of findings

- In maternity services, the families and birth forum was involved in the design of the induction of labour suite and in championing the take-up of breastfeeding rates through the use of peer supporters, as well as improving information to raise awareness and promote the service to women when they had left the hospital.
- In maternity services, lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge – a series of toolkits which are part of the productive care workstream. The toolkits help look at care in a variety of settings through the eyes of patients and service users, to help investigate what good quality care looks, sounds and feels like.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, and outpatients department.
- Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are being carried out and how decisions are made.
- Ensure that there are mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.
- Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.
- Ensure staff receive appropriate training and support through appraisal including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.
- Ensure that patients records are appropriately up dated and stored to ensure confidentially is maintain at all times in line with legislative requirements.
- Ensure that there are mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Ensure that resuscitation equipment and medication fridge temperatures in the diagnostic and imaging department are checked in accordance with trust policies and procedures.

In addition the trust should:

- Review College of Emergency Medicine audit data to ensure that patient outcomes are met.
- Continue to review and reduce the mortality outliers for the Hospital Standardised Mortality Ratio (HSMR) within the trust.
- The trust should ensure that patients who are medically fit are discharged in a timely manner to the appropriate setting to reduce the number of delayed discharges.
- The trust should ensure that medication omissions were monitored, investigated and reported in line with trust policy.
- Identify a formal board-level director who can promote children's rights and views. This role should be separate from the executive safeguarding lead for children.
- Consider the commencement of a restraint-training programme for staff in A&E.
- Incorporate the use of mental capacity assessments into the trust-wide audit of DNA CPR documentation.
- Introduce patient surveys specific to the outpatients department.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	Overall, we rated urgent and emergency services as 'good. The department was visibly clean and we observed good hand hygiene and infection control measures. Medicines were handled in accordance with legislation and guidelines. The department had sufficient nursing staff for the acuity and number of patients. Systems were in place for investigating incidents and complaints, learning lessons and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets. Policy and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to clear priorities. Patients told us they were provided with adequate pain relief. There was a rolling programme of regular training and appraisal for staff. Multidisciplinary team arrangements were in place. Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed they were treated well and with compassion. Between 2013 and 2014, the department demonstrated an upward trend for admitting, transferring or discharging 95% of patients within four hours, with every week achieving the target between October 2014 and November 2014. From June 2014 to September 2014, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to maintain compliance with national standards. There was clear leadership in A&E and managers worked closely together to monitor and improve care. Regular directorate governance and information-sharing meetings were held and there

Summary of findings

was an open and effective culture throughout. All staff exhibited high morale and pride in their work and were focused on giving patients a positive experience.

Medical care

Good

Overall, we rated medicine as good, although safety required improvement. We found that nurse staffing levels, especially overnight were concerning with levels on Ainderby ward (13.5 patients to one nurse), and Romanby ward (13 patients to one nurse). The Trust had already highlighted this as a concern and plans were in place to improve the ratios. Attendance at mandatory and safeguarding training was low on some specific wards.

Hospital Standardised Mortality Ratio compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected.

Systems were in place to report incidents, analysis and feedback was provided to staff. Most staff were aware of learning. Wards monitored safety and harm free care and results were positive, overall. The results were displayed and available to staff or patients. Wards were clean and staff were observed adhering to infection control principles. Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust guidance.

Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site. Staff were aware of the local policies and procedures. Audits were undertaken to monitor compliance with guidance Pain relief, nutrition and hydration needs were met.

The trust participated in national clinical audits. At the time of the inspection 52% of staff across the Integrated Medical Care Centre had received an appraisal and approximately 60% of staff working

Summary of findings

within the Integrated Medical Care Centre had received staff development reviews. Staff reported good working relationships within the multidisciplinary teams.
Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful.
There were processes in place to ensure most patients were cared for in the right place at the right time. Work was ongoing to further develop the medical vision and strategy at this site. Staff worked to meet the needs of individual patients. The trust had prioritised and developed a number of initiatives to improve the care of people living with dementia. Whilst the trust was proactive in planning discharge dates there were delays in discharging people who were medically fit to leave the hospital and but required a transfer to other packages of care.
There had been very recent changes to the leadership of the Integrated Medical Care Centre as part of a wider trust restructure. Staff were generally positive about the leadership and the recent appointments. However, some nursing staff commented that the matron and senior nurse leaders for the medical services were not visible and only visited sporadically. Most staff were clear about the vision and strategy for the service, especially within CDU.
Clinical governance meetings were held at speciality, group and clinical centre levels. There was generally good clinical engagement and attendance. The clinical centre risk register included most but not all the issues identified as risks during the inspection.
The trust was average for staff engagement when compared with trusts of a similar type. However, the data for medicine showed that staff responded more positively when compared to the Trust average.
There were examples of innovation and improvement.

Surgery

Good

We rated surgery services at this hospital as 'good'. There were effective arrangements in place for reporting patient and staff incidents and allegations of abuse. Staff were encouraged to report incidents

Summary of findings

and they received feedback on what had happened as a result. Staffing establishments and skills mix had been reviewed to maintain optimum staffing levels during shifts. Effective handovers took place between staff and included daily safety briefings to ensure continuity and safety of care.
There were arrangements for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment.
There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs.
Surgical services participated in national clinical audits and reviews to improve patient outcomes and had developed a number of local audits.
Mortality indicators were within expected ranges.
Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly.
We observed positive, kind and caring interactions on the wards and between staff and patients. All patients spoke positively about the standard of care they had received. All patients we spoke with felt they understood their care options and were given enough information about their condition. There were services to ensure that patients received appropriate emotional support.
Systems existed to plan and deliver services to meet the needs of local people. Services were available to support patients, particularly those living with dementia, a learning or physical disability or those whose first language was not English. There were also systems in place to record concerns and complaints raised within the division, review these and take action to improve patients' experience.
There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.
The trust's vision, values and strategy were well-embedded with staff who had a clear understanding of what these involved. Staff were aware of their individual roles and responsibilities and there was effective ward leadership; staff felt supported at a local level.

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Critical care

Good

We rated critical services at this hospital as 'good'. Effective arrangements were in place on the unit for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents, and received feedback on what had happened as a result. Nurse staffing levels were determined using an acuity tool and national guidelines were followed. The complement of medical staff and the skills mix of the medical team were suitable and in line with national guidance. Arrangements were in place for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment and care records were completed accurately and clearly. The unit appropriately assessed and responded to patient risk.

Processes were used for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. The unit performed well in comparison with similar units in terms of patient outcomes, and there were no concerning patient outcome figures. Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly to identify patients requiring visits or to discuss any changes to patient care.

The team working on the unit were caring, compassionate and patient-focused. We observed positive, kind and caring interactions between staff and patients. Patients spoke positively about the care that they received and felt they understood their care options and were given enough information about their condition. Services were provided to ensure that patients received appropriate emotional support.

The unit was an integrated critical care unit, which meant it could easily flex between level 2 and 3 beds depending on demand. The staff group were also responsive to the changing needs of patients and worked effectively to manage the workload. Quality indicators, including early readmissions, late readmissions and post-unit hospital deaths were within acceptable limits on this unit. The unit had a very low number of complaints. The vast

Summary of findings

majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated. Any learning from complaints was disseminated to staff through staff meetings and directorate updates.
Governance processes were embedded and there were appropriate processes for managing risk. The leadership team was approachable and open, and seen positively by staff. The management team had a number of effective ways of engaging with staff. Patient engagement and feedback was actively sought on the unit.

Maternity and gynaecology	**Good**	Overall maternity services were good in all areas, with an 'outstanding' rating for being well-led. The service provided safe and effective care in accordance with recommended practices. Resources, including equipment and staffing, were sufficient to meet the needs of women. Staff had the correct skills, knowledge and experience to do their jobs. The individual needs of women were taken into account in planning the level of support throughout pregnancy. Women were treated with kindness, dignity and respect while they received care and treatment. The maternity services were led by a highly committed, enthusiastic team, with each member sharing a passion and responsibility for delivering a high-quality service. Governance arrangements were embedded at all levels and enabled the effective identification and monitoring of risks and the review of progress on action plans. There was strong engagement with patients and a focus on gaining greater involvement from patients' groups who represented the local population using the service.
Services for children and young people	**Good**	We rated services for children and young people as 'good'. The children's services actively monitored safety, risk and cleanliness. We did not identify any concerns regarding nursing and medical staffing at the Friarage Hospital. At Friarage Hospital there was only one young person available to talk with during our inspection visit and they were very happy with the care they

Summary of findings

received. We reviewed 63 questionnaires submitted since 1 November 2014 and these showed that parents provided positive feedback with no negative responses.
We found that a recent service reconfiguration was being closely monitored and managed in partnership with commissioners and other healthcare providers. We found access and flow was good within the hospital and its link to the main children's services at James Cook University Hospital.
The service had a clear vision and strategy based on the National Service Framework for Children. The service was led by a positive management team who worked well together. The service regularly introduced innovative improvements with the aim of constantly improving the delivery of care for children and families.

End of life care

Requires improvement

End of Life services were caring, responsive and well-led but required improvement in order to be safe and effective. Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were not always completed in line with national guidance and trust policy. Patients who were identified as lacking mental capacity did not always have their mental capacity assessments documented.
Training and education for ward-based staff had been problematic due to issues with releasing staff from the wards to attend. The specialist palliative care team had approached this issue by delivering more informal ward-based training, however, this hadn't been recorded and so was difficult to evaluate in terms of effectiveness. We saw that education was one of the key themes identified as part of the end of life steering group work programme.
The trust had a care pathway in place which was being used during the transition from the phase out of the Liverpool Care Pathway and the introduction of a new regional pathway. The last days of life care pathway did not include specific prompts around nutrition and hydration assessments; these were sometimes missing in the pathways we reviewed, however, this had been addressed to ensure specific prompts were incorporated in the new guidance.

Summary of findings

The specialist palliative care team supported ward-based staff with end of life care and they were committed to the development of end of life care skills to improve care for patients. We saw evidence of plans to address issues identified in both internal and external audits and we saw service planning in progress centred around seven key themes identified by the end of life steering group.
We saw evidence of innovation in the form of a referral algorithm, palliative care link meetings for ward staff and the use of a fast-track information pack for rapid discharge. The focus of these innovations was to improve support and care to patients at the end of life. Patients and their relatives told us that staff were caring and compassionate and we saw the service was responsive to patients' needs. There were prompt referral responses from the specialist palliative care team and rapid discharge for patients at the end of life who wished to be cared for at home.

Outpatients and diagnostic imaging

Good

Overall, the care and treatment received by patients in the Friarage outpatient and imaging departments was effective, caring, responsive and well-led. There were some areas of improvement, particularly in safety. We found that some checks on equipment had not been carried out regularly. Additionally, in the imaging department, we found that medication stored in the drug fridge was not regularly checked to ensure that medicines were stored within the appropriate temperature parameters.
Within the outpatients department, there were concerns that the low number of registered nurses meant that the skills mix of staff was not always able to support patients' needs.
Patients were very happy with the care they received and found it to be caring and compassionate. Staff were supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because there were policies to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

Summary of findings

A number of patient information leaflets across the departments were past their review dates and there was no evidence that patient satisfaction surveys were completed specifically in relation to outpatients.
Services offered were delivered in an innovative way to respond to patients' needs and ensure that the departments work effectively and efficiently.

Requires improvement

Friarage Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Contents

Detailed findings

Background to Friarage Hospital

The Friarage Hospital was one of two acute hospitals in the South Tees Hospitals NHS Foundation Trust. The trust provided acute hospital services to the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland. The trust also provided a range of specialist regional services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria. In total, the trust had 1,351 beds across two hospitals and community services, and employed around 9,000 staff. The Friarage Hospital had 170 beds. It has been a foundation trust since May 2009.

The Friarage Hospital provided medical, surgical, critical care, maternity, and children and young people's services for people across the Hambleton and Richmondshire area. The hospital also provided urgent and emergency (A&E) and outpatient services. The A&E department was open 24 hours a day, seven days a week; 17,291 patients (of which, 5,855 were children) attended between April 2013 and March 2014. Patients were cared for in either an ambulatory care area, which included 'see and treat', rapid assessment and treatment – sometimes known as major injuries or Majors – and resuscitation.

Friarage Hospital had two wards providing surgical services, a surgical assessment unit, post-operative surgical day unit and surgical theatres providing elective and non-elective treatments.

It had one integrated intensive care unit (ITU), managed under the integrated medical care centre within the South Tees Hospitals NHS Foundation Trust. The unit was a modern facility for the care of critically ill patients. The unit covered a catchment population of around 430,500.

Following a reconfiguration of maternity services in October 2014, the maternity service at the Friarage Hospital became a separate, midwifery-led unit. It provided care for pregnant women who were medically fit, had a normal pregnancy and were at low risk of complications. Women identified as high risk were transferred to the James Cook University Hospital for consultant-led care.

The directorate of paediatrics and neonatology was responsible for services for babies, children and young people at the Friarage Hospital. The children's service at Friarage was monitored and managed by the children's management team located at James Cook University Hospital. Services at Friarage Hospital included a dedicated short stay paediatric assessment unit (SSPAU), open between the hours of 10am and 10pm seven days per week, and a children's outpatient department. The SSPAU provided short stay assessment and treatment for children under the paediatric medicine specialty. Some short stay minor surgery was also performed every week at the unit, including the specialties of plastic surgery, general, oral and community dental surgery.

The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team (SPCT). The SPCT comprised one full-time palliative care consultant and one half-time respiratory consultant with an interest in palliative care. There was an end of life lead nurse and three additional palliative care nurses. The team worked as part of a wider multidisciplinary palliative care team, providing specialist palliative care support to patients at this hospital, the James Cook University Hospital and across two community regions.

Outpatient clinics were held in two different locations in this hospital: main outpatients; and the Scott Suite. Within the main outpatients department there were 20 consulting rooms. The outpatients department ran a wide range of clinics, some nurse-led, some led by allied healthcare professionals and some by doctors across a large number of specialties such as urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ear, nose and throat (ENT), respiratory medicine and neurology. The imaging services were conducted from one location on the site and provided general radiography, computerised tomography (CT), magnetic resonance imaging (MRI), breast imaging, ultrasound scanning and fluoroscopy.

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Sandra Christie, Director of Nursing, Wirral Community NHS Trust.

Head of Hospital Inspections: Julie Walton, Care Quality Commission (CQC).

The team included CQC inspectors and a variety of specialists: consultant in emergency medicine, consultant paediatrician, consultant clinical oncologist, consultant obstetrician and gynaecologist, consultant anaesthetist, consultant in oncology, junior doctor, clinical nurse specialist, senior nurses, student nurses and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning group, local area team, Monitor, Health Education England and Healthwatch.

We carried out an announced visit on 11 December 2014. During the visit we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held a listening event on 2 December 2014 in Middlesbrough to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening event.

Facts and data about Friarage Hospital

The Friarage Hospital provided services to the people in the Tees Valley and North Yorkshire area.

Between April 2013 and March 2014, the A&E department at the Friarage Hospital saw 17,291 patients of which 5,855 were children. Following a reconfiguration of children's services in the hospital in October 2014, the A&E department no longer treated children, apart from those who self-presented with injuries. The department had seen 12,333 attendees since April 2014.

Detailed findings

The Friarage Hospital served a population of 62,389 children in the NHS South Tees area and 30,468 children in the NHS Hambleton, Richmondshire and Whitby area. During the period April 2013 to October 2014 (prior to the reconfiguration of this service) this hospital had 4,431 ordinary admissions and 602 day case admissions. In the same period, the trust reported that it had 22,590 outpatient attendances and 1,345 ward attendees.

There were a total of 124,971 outpatient appointments between April 2013 and March 2014. The ratio of new appointments to review appointments was approximately 1:3. The service delivered around 1,300 babies in 2013/14.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Requires improvement	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	☆ Outstanding	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and diagnostic imaging.

Urgent and emergency services

Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Friarage Hospital's accident and emergency (A&E) department (A&E) was open 24 hours a day, seven days a week. Patients were cared for in either an ambulatory care area, which included 'see and treat', rapid assessment and treatment – sometimes known as major injuries or Majors – and resuscitation. The adult resuscitation area had two bays, rapid assessment and treatment and the ambulatory care area had five cubicles. The department had a relatives' room located near to the resuscitation area. There were also two designated cubicles for the treatment of children. The A&E department was closely linked to the James Cook Hospital's A&E department and shared governance, management and staff arrangements.

Between April 2013 and March 2014, A&E provided a service to 17,291 patients, of which 5,855 were children. Following a reconfiguration of children's services in the hospital in October 2014, A&E no longer treated children, apart from those who self-presented with injuries. The department had seen 12,333 attendees since April 2014.

During our inspection, we spoke with approximately seven patients and their relatives, 11 staff, including doctors, nurses, allied healthcare professionals and managers. We observed care and treatment and reviewed 20 sets of care records. Prior to and following our inspection, we reviewed a range of performance information about the department.

Summary of findings

Overall, we rated A&E as good. The department was visibly clean and we observed good hand hygiene and infection control measures. Medicines were handled in accordance with legislation and guidelines. The department had sufficient nursing staff for the acuity and number of patients. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets.

Policy and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to clear priorities.

Patients told us they were provided with adequate pain relief. There was a rolling programme of regular training and appraisals for staff and the trust was ranked third in the country for their junior doctors' training programme. Multidisciplinary team arrangements were in place.

Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed they were treated well and with compassion.

Between 2013 and 2014, the department demonstrated an upward trend for admitting, transferring or discharging 95% of patients within four hours, with every week achieving the target between October and

Urgent and emergency services

November 2014. From June to September 2014, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to maintain compliance with national standards. Systems were in place for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

There was clear leadership in A&E and managers worked closely together to monitor and improve care. Regular directorate governance and information-sharing meetings were held and there was an open and effective culture throughout. All staff exhibited high morale and pride in their work and were focussed on giving patients a positive experience.

Are urgent and emergency services safe?

Good

The safety of the care provided was good. The department was visibly clean and we observed good hand hygiene and infection control measures. Medicines were handled in accordance with legislation and guidelines. The department had sufficient nursing staff for the acuity and number of patients. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets.

Incidents

- Nursing staff were knowledgeable about the reporting process for incidents using Datix (the hospital's incident reporting software system). Staff said they were encouraged and supported to report incidents.
- Staff told us they were aware of the new statutory Duty of Candour. The new regulation was introduced for NHS bodies in England in November 2014. Certain key principles are set out, including a general duty to act in an open and transparent way in relation to care provided to patients and, as soon as reasonably practicable after a notifiable patient safety incident occurs, the organisation must tell the patient (or their representative) about it in person.
- There were no Never Events (serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented) or serious incidents reported in the department between April 2013 and December 2014.
- However, there was a serious incident in the James Cook Hospital A&E department and we saw evidence of lessons learned shared with staff at the Friarage A&E department. Senior staff informed us that all serious incidents were investigated, a full root cause analysis was conducted and action plans were put in place as a result of the analysis. We reviewed the Self-harm multidisciplinary integrated care pathway document for children aged 8-17 years, which was developed as a result of the review of the serious untoward incident. This meant that learning from incidents was taking place at the strategic and operational level.

- Between 1 April 2013 and 31 March 2014 there had been 60 incidents reported in the department through the National Reporting and Learning System, 52 of which were rated as 'no actual harm', seven were rated as 'minor' and one as 'moderate'.
- Departmental mortality and morbidity meetings were held every fortnight to review the care of patients who had had complications or an unexpected outcome. All mortality and morbidity was strategically reviewed in a directorate meeting once a month, which meant there was a formal process in the department to share learning and inform practice.

Cleanliness, infection control and hygiene

- We found the environment was clean and tidy and we saw current cleaning schedules.
- Hand-washing facilities were readily available and we saw staff wash their hands and use hand gel between attending to patients. Personal protective clothing such as gloves and aprons were available in all clinical areas and the 'bare below the elbow' policy for best hygiene practice was adhered to.
- The department carried out hand hygiene infection control audits. We looked at the department's audit results and saw they had achieved 100% compliance in October 2014, 100% compliance in November 2014 and 80% compliance in November 2014. A manager told us that staff who did not meet the required standard were identified and 'on the spot' training was provided. We also read the infection control lead's feedback report to staff dated September 2014. This demonstrated that the department had a system for auditing practice and developing staff.
- A manager reported there had been no cases of hospital-acquired Methicillin-Resistant or Methicillin-Sensitive Staphylococcus Aureus (MRSA or MSSA) or hospital-acquired Clostridium difficile (C. difficile) infections between April 2013 and December 2014.
- The department had appropriate facilities for isolating patients with an infectious condition.

Environment and equipment

- There was a dedicated ambulance entrance that ensured patients had direct access to the resuscitation and major injuries (Majors) areas. People who self-referred used a separate entrance to the ambulance entrance and all entrances were clearly signposted.
- The resuscitation areas were equipped appropriately and we checked a range of resuscitation equipment, which was accessible and fit for purpose.
- We saw that equipment in the department had 'clean' labels attached that documented the time and date it was last cleaned. This meant that staff and patients could be assured that the equipment used was clean.
- In-service and portable appliance testing (PAT) of electrical equipment had been carried out in the department. 'PAT tested' labels on electrical equipment confirmed this.
- All equipment was serviced on a rolling programme basis by the medical engineering department and we saw stickers attached on some equipment that confirmed servicing and maintenance had been completed.
- There was a separate children's entrance into the department, which meant children who attended with their parent, or guardian were separated from adult patients. We found the paediatric environment was fit for purpose as the children's waiting area was situated away from the adult waiting area and was decorated with children in mind. Toys were available, clean and in good condition.

Medicines

- Medicines were stored correctly in locked cupboards or fridges. However, the treatment room where drugs were stored did not have a lock on the door. The provider dealt this with and a lock was fitted while we were in the department.
- Fridge temperatures for the A&E department were checked regularly and records showed these were correct during December 2014.
- Medical gases were found to be stored securely within the resuscitation area.
- Emergency drugs were accessible.
- We asked nursing staff about standards of checking medications before, during and after administration and found they understood the Nursing and Midwifery Council (NMC) Standards for Medicines Management. We observed nurses following NMC guidance, which confirmed what they told us.

Records

- Patient care records were in paper format and all healthcare professionals documented care and

treatment using the same document. The trust had plans for the introduction of an electronic records system. The implementation of the system was planned for April 2015.

- We reviewed 10 adult patient records and found that the records had the appropriate assessments recorded, including risk assessments, observations, care and treatment and, where necessary, discharge plans. This meant that records we reviewed for adults were completed appropriately.
- We read a clinical sister's report (September 2014) based on a recent audit of record-keeping within the department. There were conclusions drawn from the audit and staff were instructed to adhere to record-keeping standards where gaps were identified.
- We reviewed 10 paediatric care records and found that, in six of the records, a junior doctor from the paediatric assessment unit, who had not seen or treated the children, had reviewed their care and treatment. We raised this with the provider who told us that the paediatric team would collect the A&E cards for children from the previous day and review these cases any cases of concern would be discussed and escalated, with appropriate referrals made.

Safeguarding

- Medical and nursing staff were trained in safeguarding to the appropriate level. Those we spoke with knew how to identify signs of domestic violence, abuse or neglect in children and adults and how to report it. We observed a discussion at a senior meeting about a recent referral to the adult safeguarding team.
- There was health visitor liaison; health visitors reviewed all paediatric care notes and were also sent a full set of care notes for children under five years old.
- Records showed that 99% of medical and nursing staff were up to date with their safeguarding children training and 66% had completed adult safeguarding training.

Mandatory training

- We looked at departmental data for staff mandatory training relating to the period April to December 2014. All staff had completed information governance training, 56% of staff had completed manual handling training and 100% of staff had completed either basic life support or intermediate life support training.
- The department had a lead trainer and managers informed us they were taking steps to ensure that all staff completed their mandatory training modules by the deadline of March 2015.

Assessing and responding to patient risk

- We observed rapid assessment and treatment processes and found these to be appropriate. Adult patients were assessed and managed using a variety of risk assessment tools, which included the use of the National Early Warning Score (NEWS) for acutely ill patients. Children were risk-assessed using the Paediatric Early Warning Score (PEWS) system.

Nursing staffing

- Nursing numbers were assessed using the Baseline Emergency Staffing Tool (BEST).
- The overall adult nursing skills mix and numbers were appropriate and included clinical sisters, senior sisters/ charge nurses, emergency nurse practitioners (ENPs), band 5 nurses and healthcare assistants.
- ENPs – advanced trained nurses able to see, treat and discharge certain categories of patients so that patients did not have to wait to see a doctor – were employed in the department. ENPs were not counted in the shift nursing numbers due to their role being to assess, diagnose and treat patients. Three ENPs had recently been recruited and were undergoing training at the James Cook University Hospital's A&E department.
- Handovers and information-sharing sessions were held with clinical staff responsible for patient care twice a day. Any complaints, concerns or incidents were also discussed.

Medical staffing

- The College of Emergency Medicine (CEM) recommends a minimum of 10 consultants in each emergency department. Consultant cover was provided by the A&E department at James Cook University Hospital, who employed 15.4 whole time equivalent (WTE) consultants.
- Consultant cover was from 9am to 5pm, four days a week and 9am to 1pm one day a week. Out-of-hours arrangements were in place to access A&E consultant advice from either the James Cook University Hospital's A&E department or via the consultant on-call rota at this hospital.

- The hospital mitigated any risk by employing regular higher-middle-grade locums from a single agency. This ensured standards and requirements of induction, training and revalidation for locums were met. Middle grade cover was 24 hours a day, seven days a week.

Major Incident awareness and training

- The department was not designated as a 'receiving' hospital in the major incident plan; if there was a major incident; patients were taken to the James Cook University Hospital.
- There were appropriate security arrangements in the department. Security staff were employed in the hospital 24 hours a day, seven days a week, and could be summoned easily to support staff as they were located close to the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Policy and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to clear priorities. Patients told us they were provided with adequate pain relief. There was a rolling programme of regular training and appraisal for staff and the trust was ranked third in the country for their junior doctors training programme. Multidisciplinary team arrangements were in place.

Evidence-based care and treatment

- The department used a combination of National Institute for Health and Care Excellence (NICE) and CEM guidelines to determine the treatment they provided. Local policies were written in line with this and were updated if national guidance changed.
- At the monthly departmental meetings, any changes to guidance and the impact that it would have on their practice was discussed. If the department was found to be non-compliant with the guidelines, this was escalated to the Board. Subsequent amendments were made to practice and policy after being formally signed off by the Board. We saw evidence of this process and read a NICE guidance pathway that had been developed in February 2014 for the care of people who present with self-harm conditions.

Pain relief

- All of the patients we spoke with told us that they were offered and/or provided with appropriate pain relief, and adult patient records confirmed this.

Nutrition and hydration

- There was tea, coffee and water available in the department. Staff ensured that patients who needed food were offered suitable snacks.

Patient outcomes

- The hospital participated in national CEM audits so it could benchmark its performance against best practice and other A&E departments.
- Audits included the requirement for consultant sign-off; this meant there were three types of patient groups that should be reviewed by a consultant: adults with non-traumatic chest pain; feverish children less than one year old; and patients making an unscheduled return to the department with the same condition, within 72 hours of discharge. The trust was performing between the upper and lower England quartiles in all eight standards in the 2013 audit.
- We reviewed the CEM audits. Although it was acknowledged these were not recent, they were the latest audit data available at the time of inspection. In the CEM vital signs in a Majors audit of 2010/11, the department did not meet the six standards for measuring and recording vital signs after arrival or triage. The department did not meet any of the five standards for observations being repeated and recorded within 60 minutes. They did not meet the standard for abnormal vital signs being communicated to the nurse in charge or the standard for appropriate investigations being carried out and recorded before discharge.
- The department did not meet any of the 17 CEM standards for renal colic in the 2012 audit. The standard relating to recording an initial pain score was not met and put the department in the lower England quartile.
- The department did not meet standards in relation to the 20- and 30-minute targets for providing analgesia to

patients in severe pain and were in the lower England quartile for the 20-minute target, and between the upper and lower England quartile for the 30-minute target.
- The department did not meet the standards for providing analgesia to patients in moderate pain and were in the lower England quartile. The re-evaluation of pain standards were not met but the department was in the upper England quartile for reassessing severe pain within 60 minutes. None of the standards for carrying out and recording appropriate investigations prior to discharge were met but the department was in the upper England quartile for considering a radiological investigation.
- In the CEM severe sepsis and septic shock audit (2011), the department met the standard for vital signs being measured and recorded in the notes and for this standard they achieved 100% in the audit which placed them in the upper England quartile. Twelve other standards were not met, with four in the lower England quartile. These included: capillary blood glucose measurements taken and recorded on arrival to A&E; evidence in the notes that first intravenous crystalloid fluid bolus was given within one hour in A&E; evidence that urine output measurements were instituted; and the administration of antibiotics before leaving A&E.
- In the CEM pain in children audit (2011), the hospital scored 89% for asking children their pain score. They scored 86% for giving analgesia within 60 minutes, and only scored 33% for reassessing pain scores.
- We spoke with managers about the trust's most recent clinical audit programme and we read the clinical audit annual report dated 2013/14. It showed that the trust categorised its centrally coordinated clinical audit activity according to clear priorities. We saw evidence that some further CEM audits had been carried out and the results and actions were awaited.
- The trust met the national standard of 5% unplanned re-attendance to A&E within seven days (April to October 2014), apart from a slight increase in the number of re-attendances in July and October 2014.

Competent staff

- There was a rolling programme of regular training for staff, such as intermediate life support. Nursing staff told us they felt well-supported with training.
- The trust was ranked third in the country in the latest junior doctors' training survey.
- Staff were appraised regularly. Within the department, 79% of nursing staff and 100% of medical staff had had an appraisal (April 2013–October 2014) and managers were working towards 100% completion by the end of March 2015.

Multidisciplinary working

- Staff had access to mental health teams, including Child and Adolescent Mental Health Services (CAMHS). Managers acknowledged that the CAMHS service was not always timely in its response, but said it was supportive and the adult mental health service or social services covered any gaps in provision.
- A rapid response team consisting of nursing and allied healthcare professionals were available to assess and assist patients with a safe discharge home.
- Staff were aware of key contacts in other hospital teams and the protocols to follow.
- Weekly multidisciplinary team meetings were held in the department.

Access to information

- The trust was awaiting implementation of a 'real time' electronic patient record system.
- Adult patient records contained all the necessary information required for ongoing care.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before the intervention was carried out.
- Staff training on the Mental Capacity Act (2005) was conducted every three years. From January to December 2014, 78% of staff had completed training. Staff we spoke with were clear about their responsibilities in relation to patient capacity, consent and the deprivation of liberty safeguards.
- There was a dedicated, secure facility to safely accommodate patients who posed higher care and treatment risks. We saw no evidence of a clinical holding (restraint training) programme and staff told us they were not trained to restrain patients. This could put staff and patients at risk and the provider should consider the commencement of a training programme for staff.

Urgent and emergency services

Are urgent and emergency services caring?

Good

Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed patients were treated well and with compassion.

Compassionate care

- The trust used the NHS Friends and Family Test to capture patient feedback. Low response rates were common for A&E departments and managers were investigating the use of a phone text back tool to improve response rates. From April 2013 to July 2014, the trust scores were better than the England average, apart from in January 2014.
- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. Patients we spoke highly of the service and one said, "the service is great".
- We spoke with many staff of all grades who consistently displayed a passion for delivering good quality care and gave us an overall sense of caring about patients. This was also evident during our observations of interactions between patients and the staff.
- We looked at patient records and found they were completed sensitively and detailed discussions that had taken place with patients and relatives.

Understanding and involvement of patients and those close to them

- The results of the 2014 CQC A&E overall patient experience survey put the trust among the best in the country. Responses to key questions asked about a safe, effective, caring, responsive and well-led service indicated that the trust's performance was better than expected when compared to other trusts.
- Patients and relatives told us that their care and treatment was explained to them in a way they could understand and we observed this interaction throughout our inspection. One patient said, "They keep coming to tell me what was happening".

Emotional support

- Staff told us there were good links to sources of specialist support, such as counselling and the chaplaincy service.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Good

Between 2013 and 2014, the department demonstrated an upward trend for admitting, transferring or discharging 95% of patients within four hours, with every week achieving the target between October and November 2014. There were triage systems for the initial assessment and management of patients who self-referred. The national standard required 95% of patients to be seen and receive treatment by a registered healthcare professional within 60 minutes. The trust was consistently performing better than this standard.

Systems were in place for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

Service planning and delivery to meet the needs of local people

- There had been a reconfiguration of the paediatric service provision and, from October 2014, all children (apart from those who self-refer with injuries) were taken by ambulance or referred to the James Cook University Hospital A&E department.
- Certain categories of patients were taken by ambulance directly to the James Cook University Hospital A&E department; these included those suspected to be suffering from a fractured neck of femur.
- The hospital had recently opened a 'place of safety' suite for vulnerable adults detained under Section 136 of the Mental Health Act (1983) to help people recover from episodes of ill health, provide rapid access to treatment and limit the time spent in A&E.

Meeting people's individual needs

- Staff showed us a relatives' room that was available for use by family members.

Urgent and emergency services

- Interpreting services were used for patients whose first language was not English. There were language cards available for use in the department.
- We read a dementia audit dated March 2014 that had an aim for the trust to become a dementia-friendly organisation with environments and processes that caused no avoidable harm to patients living with dementia. Managers told us that the bay curtains had been replaced to comply with some of the findings of the audit.
- Staff knew about the patient passport system for people with learning disabilities used at the trust. These passports set out people's specific needs and copies were taken and placed in the care record.

Access and flow

- There were triage systems for the initial assessment and management of patients who self-referred. The national standard required 95% of patients to be seen and receive treatment by a registered healthcare professional within 60 minutes. The trust was consistently performing better than this standard.
- Trusts within England are set a government target of admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. The department's performance in meeting the four-hour target showed a much-improved upward trend in 2013/14. This trend did not continue initially in 2014, with the first half of the year seeing a negative trend; however, this was reversed in October and November 2014 with every week achieving the target.
- The total time in the department for 95% of patients who were admitted was less than 4 and a quarter to 5.5 hours.
- The national standard for patients who arrive by ambulance stated they should receive an initial assessment by a registered healthcare professional within 15 minutes of arrival into the department. We read departmental data that showed from April to June 2014 and August to September 2014, the national target was not met. However, the longest waiting time was only 19 and 18 minutes respectively. Between June and September 2014 the national target of 15 minutes was exceeded.
- A&E departments across England have to record the rate of people who leave the department without being seen. The quality threshold is 5%; the department had a rate of less than 3.5% of people who left without being seen by a doctor or a nurse (April to October 2014).

Learning from complaints and concerns

- The department promoted the Patient Advice and Liaison Service. Information about this service was displayed in patient areas.
- Staff were aware of how to manage complaints and how to support patients who wished to make a complaint. Lessons learned from complaints and patient feedback were shared in staff meetings.

Are urgent and emergency services well-led?

Good

There was clear leadership in A&E and managers worked closely together to monitor and improve care. Regular directorate governance and information-sharing meetings were held and there was an open and effective culture throughout. All staff exhibited high morale and pride in their work and were focused on giving patients a positive experience.

Vision and strategy for this service

- The trust's vision was present throughout the department.
- Staff were able to repeat the vision to us during individual conversations.

Governance, risk management and quality measurement

- Regular governance meetings attended by senior A&E staff were held within the directorate. Complaints, incidents, audits and quality improvement projects were discussed.
- A weekly breach meeting was held to discuss any breaches of national targets and to improve services.
- A risk register for A&E was in place with appropriate actions documented.

Leadership of service

Urgent and emergency services

- There was clear leadership for the department and the directorate as a whole. Managers were visible in the department and we saw them work quickly on issues to ensure improvements were made.
- Managers took learning from cases and incidents seriously. We saw evidence of improvements made.

Culture within the service

- There was an open and effective culture in which staff said they felt empowered to take responsibility, make suggestions and report any incidents.
- Staff exhibited high morale, pride in their work and a drive to give a positive experience to patients.

Public and staff engagement

- Staff said they were part of a team that was not hierarchical and that all managers engaged with them.
- There was a strong drive to use patient information, such as the NHS Family and Friends Test results to improve the service.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members and staff said they were able to suggest ideas that would improve practice.
- A number of initiatives had been instigated to try to keep people out of hospital, especially during the winter period. For example, the department was working closely with a 'hospital at home' service run by volunteers who helped to ensure that elderly or vulnerable patients could return home without being admitted. The A&E department worked hard to prevent unnecessary patient admissions, to improve patient flow and expedite discharge.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The South Tees Hospitals NHS Foundation Trust provides medical care, including older people's care across two sites; The James Cook University Hospital (JCUH) in Middlesbrough and the Friarage hospital in Northallerton. There were 69,331 medical admissions to the Trust in 2013-14 of which 47% of these were emergency admissions and 6% elective. The remainder were day cases.

The trust had a number of clinical centres through which it managed the delivery of services. Overall there was approximately 1860 medical staff. Medical care was provided though the Integrated medical care centre, the Speciality medicine centre and the Tertiary services centre. On the Friarage site there were two general medical wards; Ainderby and Romanby and the Rutson rehabilitation unit which included the care of stroke patients. There was also a Clinical Decisions Unit (CDU).

At the Friarage hospital we looked at the care records of over 16 patients and 20 prescription charts. We spoke with 12 patients and relatives, over 20 staff, including doctors, nurses, therapists, pharmacists and managers. We visited Ainderby, Romanby and Rutson wards as well as the CDU, and carried out observations on the areas we visited. Before the inspection, we reviewed performance information from and about the trust.

Summary of findings

We rated medical care as good overall, however safety required improvement. We found that nurse staffing levels, especially overnight were concerning with levels on Ainderby ward (13.5 patients to one nurse), and Romanby ward (13 patients to one nurse). The Trust had already highlighted this as a concern and plans were in place to improve the ratios. Attendance at mandatory and safeguarding training was low on some specific wards.

Hospital Standardised Mortality Ration compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected.

Systems were in place to report incidents, analysis and feedback was provided to staff. Most staff were aware of learning. Wards monitored safety and harm free care and results were positive, overall. The results were displayed and available to staff or patients. Wards were clean and staff were observed adhering to infection control principles. Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust guidance.

Medical care (including older people's care)

Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site. Staff were aware of the local policies and procedures. Audits were undertaken to monitor compliance with guidance Pain relief, nutrition and hydration needs were met.

The trust participated in national clinical audits. At the time of the inspection 52% of staff had received an appraisal and approximately 60% of staff working within the integrated medical care centre had received staff development reviews. Staff reported good working relationships within the multidisciplinary teams.

Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful.

There were processes in place to ensure most patients were cared for in the right place at the right time. Work was ongoing to further develop the medical vision and strategy at this site. Staff worked to meet the needs of individual patients. The trust had prioritised and developed a number of initiatives to improve the care of people living with dementia. Whilst the trust was proactive in planning discharge dates there were delays in discharging people who were medically fit to leave the hospital and but required a transfer to other packages of care.

There had been very recent changes to the leadership of the integrated medical care centre as part of a wider trust restructure. Staff were generally positive about the leadership and the recent appointments. However, some nursing staff commented that the senior nurse leaders for the medical services were not visible and only visited sporadically. Most staff were clear about the vision and strategy for the service, especially within CDU.

Clinical governance meetings were held at in the integrated medical care centre at centre, service group and directorate levels. There was generally good clinical engagement and attendance. The clinical centre risk register included most but not all the issues identified as risks during the inspection.

The trust was average for staff engagement when compared with trusts of a similar type. However, the data for medicine showed that staff responded more positively when compared to the Trust average.

There were examples of innovation and improvement.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Nurse staffing levels, especially overnight were concerning with levels on Ainderby ward (13.5 patients to one nurse), and Romanby ward (13 patients to one nurse). The Trust had already highlighted this as a concern and plans were in place to improve the ratios. Attendance at mandatory and safeguarding training was low on some specific wards.

Systems to monitor medicine administration and storage required improvement. Resuscitation equipment was not routinely checked on Romanby ward.

Systems were in place to report incidents, analysis and feedback was provided to staff. Most staff were aware of learning. Wards monitored safety and harm free care and results were positive, overall. The results were displayed and available to staff or patients.

Wards were clean and staff were observed adhering to infection control principles.

Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust guidance.

Incidents

- In 2013/14 there were 46 serious incidents (SI) reported within medicine across the trust, 25 of which related to pressure ulcers.
- There had been 128 (2.9%) incidents graded moderate or above across the Integrated Medical Clinical Centre between April 2014 and September 2014. This was monitored monthly.
- There were systems in place to report incidents. Incidents were reported using an electronic Datix system. Staff told us they were aware of how to use the system to report incidents.
- We saw in staff meeting notes from the wards which indicated that incidents had been discussed.
- All incidents relating to dementia or people with a learning disability were highlighted and sent to the dementia and safeguarding leads for the Trust where any themes or trends were then reviewed.
- Some staff told us about lessons learnt bulletins which were circulated by the Trust to increase learning from incidents.
- There were centre-wide Mortality and morbidity meetings and on a bi-monthly basis these also covered clinical incidents. There were also weekly mortality reviews which were run by an intensivist doctor.
- An example of learning from an SI included the deterioration of patient that had not been escalated promptly to critical care staff. A root cause analysis had been completed and the main action was to formulate common documentation across both the James Cook and the Friarage hospital sites.

Safety thermometer

- The safety thermometer was clearly displayed and up to date on all wards.
- The rates of pressure ulcers (total 528) and falls (total 223) was relatively consistent throughout the 12 months to July 2014.
- The were 151 catheter acquired urinary tract infections during the 12 months to July 2014 and these showed slight fluctuations by month throughout the year.
- There was a falls strategy group that met quarterly and wards had fall link nurses who provided local leadership for falls prevention.
- The CCG had agreed a CQuIN (Commissioning for Quality and Innovation) with the Trust to reduce pressure ulcers. The trust has set up a collaborative to reduce the number of pressure ulcers which has included education and training of staff. This has seen a reduction in 7% of grade 2 pressure ulcers and 25% of grades 3 and 4. However, in the minutes of the Integrated medical care centre board meeting in September 2014 concern were raised around the pressure ulcer target. The minutes stated that the position was 8.31 against a target of 5.43 for month five.

Cleanliness, infection control and hygiene

- All areas that were inspected were clean. There were routine deep cleans of areas and wards.
- We saw staff wash their hands and use hand sanitising gel between patients. 'Bare below the elbow' policies were adhered to.
- We observed that staff wore personal protective equipment and staff applied the principles of infection control.

- Infection control information was visible in most ward and patient areas.
- Clear signs, which were understood by staff, were present on the ward where there was an infection risk.
- Equipment was clearly marked as clean.
- In 2014/15 there were three cases of MRSA attributed to the trust up to September 2014. Post infection reviews had been held with the CCGs and action plans implemented. From August 2013 to July 2014, five cases had been reported.
- The trust did not achieve its C Difficile target of having less than 37 cases in 2013/14. There were 57 cases reported.
- There were six C. Difficile cases reported to October 2014, taking the total to 30, which was one above trajectory for a full year target of 49.
- The trust had put measures in place which included short term senior support, review panels, creation of an in house dashboard and comprehensive action plans.
- Over 95% of staff in the medical centres responded positively in the 2013 staff survey to way that they had training, learning or development in infection control (e.g. guidance on hand-washing, MRSA, waste management, disposal of sharps / needles)

Environment and equipment

- Dementia environmental audits had been completed and action plans were in place to improve the environment.
- We saw resuscitation equipment was mostly checked and recorded daily apart from on Romanby ward where this equipment had not been recorded as checked daily; only half of the days had records against them.

Medicines

- Following substantial pharmacy staff investment all clinical areas will have dedicated pharmacist support by 1 January 2015.
- The chief pharmacist told us that currently 60% of patients had medicines reconciled by pharmacy staff. NICE guidance recommends that all patients should have medicines reconciled within 24 hours or earlier if clinically necessary.
- Weekly stock checks were observed.
- Clinical pharmacists and pharmacy technicians provided medicines management support including medicines reconciliation on admission and regular prescription review to all clinical areas.
- Pharmacists completed monthly audits of antibiotic use on each ward and shared the results with the ward teams. Audits demonstrated good compliance with trust policy for the use of antibiotics, a key factor in reducing the incidence of c.difficile and MRSA.
- Medicine fridge temperatures were not monitored in line with Trust policy. The temperature records on Romanby and Rutson ward were poor.
- Controlled drugs were stored securely and fully recorded. Stocks were regularly checked by nursing and pharmacy staff. A full audit of the management of controlled drugs on medical wards had been completed in September 2014 and the results followed up by the clinical pharmacist.
- We looked at the medicine records for 12 people admitted to Ainderby and Romanby wards and saw some isolated gaps where medicines administration had not been recorded. The pharmacist on the wards told us that data on medicines omissions was not routinely captured and the ward sister and matron confirmed that medicines omissions were not part of regular nursing ward checks. We found that these omissions had not been picked up, or investigated and reported in line with trust policy. For example of an omission was a drug for Parkinson's which is a critical list medicine and should have been reported as an incident on the trusts electronic reporting system.
- We were told by staff that on the Rutson rehabilitation Unit a pharmacist visited once or twice a week. We checked the medicine records for four people and they were fully completed with no significant gaps and we saw evidence of pharmacist review of prescribing.
- Overall reporting and acting on errors was good. Staff who made medication errors were then supported by a WASP (Witnessed assimilation supervised and proficient) competency framework.

Records

- The trust had just completed the roll out of IT tablets/ phones which were used to record people's observations such as heart rate and blood pressure. This helped to monitor more effectively changes and trends in these observations.
- The Patient Status at A Glance (PSAG) board on each ward used a combination of symbols to help anonymise patient information from the understanding of visitors and passers-by. On most wards the PSAG boards were in full view.

- Almost all of the nursing care records we reviewed were comprehensive and included completed risk assessments and care plans for such areas as oral hygiene, malnutrition, moving and handling, pain management and falls. A small number of records had some omissions; this was mainly in relation to patient identifiers on notes. For example a small number had a patient's name but no other identifier and on a few fluid balance charts there was no patient name or identifier. They were stored away from public view.

Safeguarding

- There were a number of safeguarding courses, relating to both children and adults, which staff were required to complete dependent on their roles. Figures provided by the trust indicated that uptake of the training by ward was variable. There was 80% of staff on CDU who had completed their adult safeguarding training compared with 48% on Romanby ward, 78% on Ainderby ward and on 77% Rutson ward.
- Both the nursing and medical staff we spoke with were aware of who to contact regarding safeguarding concerns.
- Guidance information was readily available.

Mandatory training

- Courses included as part of mandatory training were fire safety; health and safety; infection prevention and control; information governance; the mental capacity act, patient safety; safeguarding; basic life support; moving and handling and; dignity at work- valuing equality and diversity.
- Overall the integrated medical care centre staff had achieved 68% compliance with mandatory training requirements.
- The training completed varied considerably from ward to ward. On Ainderby ward it was 73% overall compared with 53% on Romanby, 67% on Rutson and 84% on the CDU.
- There was a CQUIN (Commissioning for Quality and Innovation) target in place to provide dementia training for all 9,000 staff over a five year period. We saw records that indicated that 2,500 had received training in 2013/14 and that the trust was on target to deliver training to a further 2,500 during 2014/15.
- Some staff commented that is was sometimes difficult to do essential training due to staffing levels.

Assessing and responding to patient risk

- Every ward used an early warning score (EWS) system to help identify and manage patients whose condition deteriorated. Patient observations were mostly recorded appropriately and concerns were escalated in accordance with the guidance.
- Nursing staff reported good responses from medical staff when a patient's condition deteriorated.
- A critical care outreach team was available up to 7pm seven days per week to support staff with patients who were at risk of deteriorating.
- CDU had four beds with monitors for cardiac patients. There were also 12 mobile telemetry sets for use in other parts of the hospital which were monitored through CDU. A cardiac nurse was allocated to the telemetry patients 24 hours a day, seven days a week.
- The Hospital at night medical handover included discussing individual patients who were most critical or likely to deteriorate to ensure continuity of care and management of their risk of deterioration. Handovers were recorded and included information on which doctors were present at the handover from the day and night teams. The handover included listing patients by ward, concerns raised, actions required and when the actions were completed.
- Overnight there were two senior nurse practitioners (Bands 6 and 7) on duty for the hospital with clinical assessments skills as part of the "HOOT" (Hospital Out of Hours team). These roles helped to assess and respond to any clinical risks overnight. All medical patients were admitted overnight by the nurse practitioners.
- We had concerns that patients who required non-invasive ventilation were being cared for on the general medical wards at the Friarage hospital and not within a dedicated setting. These patients were at risk of deterioration.

Nursing staffing

- The hospital used the Safer Nursing Care Tool to determine the required levels of nurse staffing for each ward. Nursing acuity audits were started in the late spring/early summer 2014 and were completed for four weeks every quarter.
- We were told there were 20 registered nurse (RN) vacancies within the integrated medical care centre, most of which were on the acute medical wards including those at the Friarage.

Medical care (including older people's care)

- We were concerned about the nurse staffing levels overnight, especially on Ainderby ward (13.5 patients to one nurse), and Romanby ward (13 patients to one nurse). The Trust had already highlighted this as a concern and plans were in place to improve the ratios. This included moving to a model of three nurses on nights where there were more than 24 beds or if the acuity of patients required more nurses. At the time of the inspection the proposals for Romanby ward, Ainderby ward and CDU were to be implemented by February 2015.
- We reviewed the staff roster for the four weeks commencing 6 October 2014 on Ainderby ward and found that overnight there were two RNs and two HCAs on duty for a ward of 27 beds.
- We had concerns that the planned staffing levels were not based on accurate dependency levels for patients requiring non-invasive ventilation (NIV). In accordance with the Intensive Care Society (2009) definitions of levels of care, these patients required Level 2 care. Staffing levels had not been calculated based on them requiring Level 2 care. At the time of our inspection Romanby ward had two patients requiring NIV with staffing levels overnight as indicated above.
- Some staff were concerned about staffing levels specifically for patients who had an raised EWS and the ability to release staff for training. We noted that NIV training had been cancelled on Ainderby ward due to staff shortages.
- Patients needing Level 2 care require a RN to patient ratio of a minimum of 1:2 for at least the first 24 hours to deliver direct care in accordance with the Intensive Care Society core standards for intensive care units (2013) and the British Thoracic Society (BTS) guidelines (2008)
- Nursing handovers occurred at least twice a day on wards. We reviewed handover sheets and found that these provided enough detail for staff to care for patients.
- The trust did not have its own internal bank staff. The majority of the agency staff used were from NHS professionals; many of which were their own staff working additional shifts.

Medical staffing

- The ratio of consultants to other medical staff was better than the England average. There were 276 whole time equivalent (WTE) medical staff within medicine of which 41% were consultant posts which was better than the England average of 33%. Middle career and registrar groups were similar to the England average however there were 15% junior doctors compared to 22% nationally.
- There was appropriate consultant cover and junior doctor availability. Consultants were very visible and junior doctors commented positively on supervision, senior support and availability of consultants.
- There were no consultants routinely on site overnight. Consultant cover was provided by an on call system.
- There was a medical registrar on duty overnight, based in the CDU, with support from a Foundation Year doctor; both of which were part of the hospital at night team.
- There was a high level use of registrar level locums at the Friarage: approximately 33%. We were told that the Trust had been unable to recruit to the required posts. The majority of the locums were used on a regular basis and so were familiar with the hospital and its clinical procedures.
- Medical staff reported good communication and handover of patients. Handovers included a review of patients and also staffing.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with were aware of this.
- The trust and its partners had escalation/resilience plans which were enacted when required - North East Escalation Plan (NEEP).
- Daily teleconferences were held to manage winter pressures which included the Trust's silver on call managers, the local CCGs, the local authorities and other local NHS trusts.
- Winter pressure arrangements were in place. However, some staff were concerned about the closure of five bedded bay on Ainderby ward and how this might impact on patient flow and care.

Are medical care services effective?

Good

Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site. Staff were aware of the local policies and procedures. Audits were undertaken to monitor compliance with guidance. Pain relief, nutrition and

hydration needs were met. The trust participated in national clinical audits. At the time of the inspection 52% of staff had received an appraisal and approximately 60% of staff working within the integrated medical care centre had received staff development reviews. Staff reported good working relationships within the multidisciplinary teams.

Hospital Standardised Mortality Ratio compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected.

Evidence-based care and treatment

- Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site. Staff were aware of the local policies and procedures.
- Audits were undertaken to monitor compliance with guidance, for example audits regarding the use of antibiotics, cardiac rehabilitation and Troponin testing which measures the levels troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. These audits were discussed at clinical governance meetings.
- The trust had also audited itself against the NICE guidance for dementia in 2013 and as a consequence put action plans in place. For example to deliver training to FY1 and FY2 doctors in the prescribing of medication for dementia. A further internal audit was completed in in August 2014 against 48 standards which highlighted the main issue as being poor pain management. Each clinical centre developed an action plan. Actions taken included the development of a flow chart to seek mental health support and a pain assessment tool using Facial Location Assessment.
- There were local policies and procedures in place which staff followed to ensure that patients received the right care and treatment, for example the multi-disciplinary integrated care pathway for deep vein thrombosis and the diagnostic pathway for a patient with suspected pulmonary embolism.

Pain relief

- Pain assessments were carried out and recorded. Pain scores were included on the medical assessment proforma.
- Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief could be accessed via medical staff, if required.
- Patient records indicated that there were care plans in place to manage people's pain and four hourly checks were recorded
- Patients told us they were asked about their pain and if they required any pain relief. Patients we spoke with had no concerns about how their pain was controlled.

Nutrition and hydration

- Protected meal times were in place and we observed these were adhered to in most cases.
- Patients were assessed regarding their nutritional needs and care plans were in place.
- Systems were in place to identify patients who needed additional support with eating and drinking, such as the 'red tray and jug' system.
- We observed patients being supported to eat and drink. Patients were often supported by volunteers trained as "Buddies" on a lunch time. Staff told us buddies provided support five days per week at lunch times and one to two evenings a week.
- Drinks were readily available and we saw that drinks were in easy reach of patients.
- Food and fluid intake were recorded in almost most cases.
- The Patient-led assessments of the Care Environment (PLACE) 2014 survey indicated that the Trust (91%) was slightly better than the national average (90%) with regard to patient's comments on the food provided.
- Most patients we spoke with commented that the meals were good.

Patient outcomes

- Hospital Standardised Mortality Ratio compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected.

Medical care (including older people's care)

- According to the Trust's Quality Accounts there were 35 national clinical audits and five national confidential enquiries during 2013/2014, which covered relevant health services that the trust provided. During that period the Trust participated in 97% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
- The national diabetes inpatient audit (NaDIA) September 2013 indicated that out of 21 indicators the Friarage hospital was better than the England median in ten areas and worse than in nine. Concerned re foot checks. A business case was written for extra specialist nurse but not approved at the time of the inspection.
- The relative risk of re-admission for both elective and non-elective medicine was higher than England average of 100 for 2013-14, especially in elective clinical haematology (123) and gastroenterology (127). Non-elective cardiology (119) and general medicine (118) were also worse than the England average. Non-elective geriatric medicine (74) was better than the England average.
- The number of medical admissions was higher than the national average. The trust had been working with the CCG to develop alternate pathways for patients who may not require an emergency admission including developing an ambulatory care model. Also local GPs had direct access via a phone and pager system to medical clinicians to obtain clinical advice. We were told that one in six calls resulted in an admission to medical wards.
- The percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average.
- The percentage of cancer patients seen by a specialist within 2 weeks (urgent GP referral) and the percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment were both similar to the England average.
- All the national cancer targets were met in quarter two of 2014/15 apart from the 62 day screening Cancer wait times.

Competent staff

- At the time of the inspection 52% of staff across the integrated medical care centre had received an appraisal and approximately 60% of staff working within the integrated medical care centre had received staff development reviews.
- Figures from the 2013 staff survey indicated that 81-82% of staff in the medical centres had in the last 12 months, had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.
- There was a clinical guideline for the clinical supervision for professionally registered staff.
- Clinical supervision of nursing staff was variable across the integrated medical care centre. There were monthly meetings held which focussed on a specific topic and had an open session for staff to raise clinical issues. Some nursing staff told us they did not receive clinical supervision.
- Trainee doctors told us that were supported and supervision was good.

Multidisciplinary working

- Staff across the medical division reported very good working relationships within the multidisciplinary teams.
- There was internal multi-disciplinary working (MDT) both between specialities and with allied health professionals.
- There was a "Hot geriatric clinic" run from the CDU twice a week to help prevent avoidable hospital admissions. GPs were able to refer patients to the clinic where a multidisciplinary team reviewed the patients. The team included consultants, case manager, social worker, physiotherapists and OTs. The case managers were funded by the local CCG.
- Staff told us there was no MDT for gastroenterology or respiratory services at the Friarage hospital.
- There is a hospital mental health liaison team which is provided by another local trust. The team is based at James Cook Hospital and available 8am to 8pm daily at the Friarage hospital.

Seven-day services

- Medical staff reported positively about senior medical and consultant cover. Ward rounds were undertaken Monday - Friday. On CDU there were consultant-led ward rounds seven days per week.

Medical care (including older people's care)

- There was a Hospital at night system in place which included verbal and written handovers of ill patients from the day shift to the night shift. Doctors we spoke with commented positively about the effectiveness of the hospital and night system.
- There was access to critical care outreach services seven days a week up to 7pm each evening.
- Availability of therapy services varied by ward. There was a physiotherapy room on Rutson ward with two regular physiotherapy staff. A qualified physiotherapist was present two days per week. There was also peripatetic support from both dieticians and speech and language therapists.
- There was five day working for both physiotherapists and occupational therapists. There was some limited physiotherapy cover at weekends for patients with acute respiratory illnesses.
- Pharmacy services were available seven days a week, although there were limited operating hours on a weekend. There were pharmacists on site Monday to Friday.
- A pharmacy was open until 2pm on a Saturday and Sunday. There were other mechanisms in place to access medicines outside of the hours including an on call pharmacist. Both a pharmacist and a ward manager confirmed that they can access medicines at weekends including discharge medication.
- X-rays and blood transfusion services were available 24hours every day.

Access to information

- Staff reported prompt response to information and test results.
- Discharge letters were sent to GPs on discharge. The trust aims to send out all discharge summaries within 24 hours of discharge. In 2013/2014 the Trust maintained 90% compliance with this standard for electronic discharge summaries
- The Patient Status at A Glance (PSAG) board on each ward provided key information about patient treatment and progress, using a combination of symbols to anonymise patient information from the understanding of visitors and passers-by. The board highlighted factors that might have been, or was, causing delay. Hold-up points were very clear to see, which allowed senior ward staff to take corrective action.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information regarding consent and mental capacity were available to staff on the trust intranet.
- Information showed that, some staff on all wards were expected to have completed training in the Mental Capacity Act. Training was variable across the wards ranging from only 48% on Romanby ward to 74% on CDU and 85% on Ainderby Ward.
- Staff demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS). During our visit we saw an application for DOLS which had been completed correctly.

Are medical care services caring?

Good

Almost all patients and relatives at the Friarage hospital told us that they, or their relatives, had been treated with compassion and that staff were polite and respectful.

The percentage of patients who would recommend the services was consistent with or higher than the national average in December 2014. The trust performed around the same as other trusts in relevant questions in the CQC inpatient survey.

Patients we spoke with were aware of what treatment they were having and understood the reasons for this and, in some cases, had been involved in the decisions.

Most patients said they felt supported by staff including clinical nurse specialists who worked at the hospital.

Compassionate care

- The results of the Friends and Family test for the Trust was consistent with the England average. The Friends and Family Test requires all patients, after discharge from hospital, to be asked: How likely are you to recommend our ward to friends and family if they needed similar care or treatment? Of those that responded in December 2014 97% said they would be likely to recommend the hospitals compared with 95% nationally.
- The trust performed around the same as other trusts in the CQC inpatient survey for 2013.

Medical care (including older people's care)

- The cancer patient experience survey results for 2013/2014 for inpatient stays showed the trust was in the top 20% nationally for 18 out of 34 questions with only one question in bottom 20% which was whether a patient's health got better or remained about the same whilst waiting for treatment which was 77% for this trust compared to 835 nationally.
- The Patient-led assessments of the Care Environment (PLACE) 2014 survey showed that the for the Friarage hospital (92%) was better than the national average (87%) for privacy, dignity and wellbeing.
- Throughout the inspection, we observed patients were treated with compassion and respect and their dignity was preserved.
- We spoke with over 20 patients and relatives throughout the inspection. Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful. Where this was not the case, staff responded appropriately to concerns raised.
- Comments included "I feel involved in my treatment", "I'm pleased with my care", "I'm not involved, just told what is happening" and "The physio is very caring".

Understanding and involvement of patients and those close to them

- Most patients felt that they were listened to by staff.
- Patients were aware of what treatment they were having and understood the reasons for this and, in some cases, had been involved in the decisions.

Emotional support

- Most patients that we spoke with said they felt supported by staff.
- There was a range of clinical nurse specialists at the trust. Patients and staff spoke positively about their input.
- The trust had service level agreements in place to provide support for people with mental health needs.

Are medical care services responsive?

Good

There were processes in place to ensure most patients were cared for in the right place at the right time. Work was ongoing to further develop the medical vision and strategy at this site.

Staff worked to meet the needs of individual patients. The trust had prioritised and developed a number of initiatives to improve the care of people living with dementia.

Whilst the trust was proactive in planning discharge dates there were delays in discharging people who were medically fit to leave the hospital and but required a transfer to other packages of care.

Service planning and delivery to meet the needs of local people

- Deprivation in South Tees is higher than average, with some areas of considerable deprivation on a par with the most deprived areas of the country.
- The services at the hospital were predominantly commissioned by NHS Hambleton, Richmondshire and Whitby Clinical Commissioning group (CCG) and NHS South Tees CCG to meet the needs of the local people.
- Based on engagement with patients, the public, staff and key stakeholders the trust had identified clinical priorities for 2014/15 which included improving the recognition and treatment of the deteriorating patient, improving nutrition for patients with dementia, and ensuring the right numbers of staff with the right skills to meet patients' needs.
- A transformation and reconfiguration plan was in place for acute and community provision to better meet the needs of the local population. Work was ongoing to further develop the medical vision and strategy at this site.
- Generally, staff we spoke with agreed there were a sufficient number of hospital beds available for the population, but there was an issue with delayed discharges which meant that there were shortages of beds.

Access and flow

Medical care (including older people's care)

- Patients were predominantly admitted from the emergency department (ED) to the CDU. This was based on established criteria. Patients requiring longer than 24 - 72 hours in hospital were then transferred to another ward following the period of assessment.
- We saw that estimated dates of discharge were planned for most patients. The use of the planned discharge date had increased from 85% in March 2013 to 98% in March 2014.
- However, trust-wide delayed transfers of care (32%) were significantly worse than the England average (19%). Delayed discharge rates as a percentage of occupied beds had reduced to 3.48% which was below the 4% threshold. This issue affected all hospitals at the trust. The trust was working with partners to deliver sustained improvement; however there were significant numbers of delayed discharges within the medical wards. The delayed transfers of care were predominantly attributed to waiting for the completion of assessments.
- The trust had done a bed utilisation review using an IT system to identify which patients were delayed discharges.
- There were discharge teams at the hospital who supported patients and staff with complex discharges. Case managers have been appointed to help secure more timely discharges for patients. There was a case manager working on CDU who was funded by a CCG in recognition of the requirement of a whole system approach.
- Each day the case management team produced a "Ready for discharge" list which was widely circulated. Most patients with delayed discharges were waiting for a DST (Decision Support tool) meeting, which were led by the CCGs. The DSTs followed after a nursing assessment had been completed and were held to decide on the most suitable placement and funding for each person. DST meetings were booked in advance with a set number of slots, usually ten, allocated per week. There were not enough slots for the number of patients requiring them. Staff told us that there were approximately 15 nursing assessments completed each week which then required a DST slot.
- We were told that on the 7 December 2014 there had been 68 patients with delayed discharges across the trust.
- On the 9 December 2014 on the ready for discharge list there were 32 medical patients across the trust with delayed discharges; 11 of which were waiting for a DST, six were related to family choice of care and eight were waiting for a bed in a community hospital.
- On the 10 December 2014 there were between 40-44 patients with delayed discharges across the trust: 16 – 18 patients were waiting for a DST, 2-4 were waiting for a nursing assessment; eight were post DST but awaiting family choice of a care facility and 12 were awaiting community rehabilitation beds.
- There were community matrons in post to provide an in-reach service to the acute wards with the intention of ensuring support packages were in place in community services. This service operated Monday – Friday at the time of the inspection but plans had been agreed to expand the service in January 2015 to 8am – 11pm seven days a week. This included liaison work with GP practices.
- There were community services which the trust could access seven days a week to enable discharge, for example, access to "Rapid social", "Rapid health" and "Rapid therapies". Responses were usually within two hours and care packages for a week to ten days were provided.
- The trust's referral to treatment time (percentage of people treated within 18 weeks) was above the national standard but below the England average. Some specialities, for example general medicine, gastroenterology, geriatric medicine and neurology were achieving 100% for patients who were admitted.
- The Trust's emergency medical admissions were higher than the national average.
- There was an ambulatory care service, run by Band 7 nurses, which operated from 8am to 8pm. This included a number of elements to provide care closer to people's own homes and avoid admission where possible. For example there was out-patient antibiotic therapy where IV lines were placed in CDU and the medication administered by the patient, a district nurse or within CDU. The service also reviewed some patients who had attended out of hours, for example patients with DVT (Deep vein thrombosis).

Meeting people's individual needs

- Translation services were available and staff knew how to access these. Staff commented that translation services were rarely used.
- We noted that information leaflets were available for patients, but these were not always readily available in languages other than English.
- The trust had developed clinical guidance to help support patients who required enhanced observation, for example supporting someone with confusion or dementia related problems. There were levels 0-3 of enhanced observation with a level 3 patient requiring one to one support. This was factored into daily staffing figures and was also used at the daily bed meetings to help prioritise staffing levels. We saw examples of additional staff being employed to provide the individual enhanced care for patients.
- Intentional rounding, to maintain patient safety, was in place and we saw completed documentation to say it had been recorded. This included checking to see if a call bell was within reach, ensuring the patient was comfortable and whether they required drinks, snacks or the toilet.
- There was a trust-wide team of staff to support people with learning disabilities. Staff on the wards we visited were aware of the team and also the use of patient passports. These provided information to health professionals about the likes, dislikes, communication and support needs of people with learning disabilities.
- There was a small team of dementia educators within the trust. A new dedicated dementia educator funded by Hambleton, Richmondshire and Whitby CCG started in December 2014 to support staff in developing an understanding of dementia and how to provide appropriate care.
- To help support people living with dementia the Trust operated a "Forget me not" scheme. This included a leaflet completed with the patient and/or their family which was kept near the patient for staff to use. It included information staff needed to know to care for patients such as food likes and dislikes, usual sleep routine and how to identify when someone was in pain. We also saw the use of "Forget me not" magnets near patients' beds to help staff identify patients who were living with dementia.
- There was also a service level agreement with a local mental trust to provide more specialised dementia care as required.
- There were staff who were identified as dementia leads to help support other staff in their understanding and care of patients living with dementia.
- We saw that patients living with dementia were usually accommodated in a bay nearest to a nurse's station or in a visible side room to help observation and ensure that the patients were safe.
- Ward staff were able to access the Hospital Mental Health Liaison Team from 8am – 8pm seven days per week; they offer support and advice to staff when nursing patients with an existing diagnosis of dementia or a newly diagnosed dementia. A referral system is used, however should emergency situations arise ward staff were able to bleep members of the team to attend the ward environment immediately.
- Some of the nurse's stations were located within the bays so that nurses were able to respond quicker to their patients and also catch up on paper work while there.

Learning from complaints and concerns

- The trust had acknowledged that the timeliness of responses to concerns had been an issue. The Trust told us they had involved Healthwatch, the Council of Governors and the Patients Association in a review of the Complaints policy.
- The corporate Complaints team held the action plans from Complaints centrally and worked with the clinical centre leadership to ensure the actions were completed.
- The number of complaints overall have increased steadily since 2010/11. The Trust advised us that if taken as a percentage of activity, complaints remained approximately 0.2% of all spells.
- Learning from complaints and concerns was not consistent across the medical wards. Staff were aware of the complaints process and some areas could provide examples of improvements to practice as the result of complaints and how this information was shared.

Are medical care services well-led?

Good

There had been very recent changes to the leadership of the integrated medical care centre as part of a wider trust restructure. Staff were generally positive about the leadership and the recent appointments. However, some

nursing staff commented that the matron and senior nurse leaders for the medical services were not visible and only visited sporadically. Most staff were clear about the vision and strategy for the service, especially within CDU.

Clinical governance meetings were held in integrated medical care centre, service group and directorate level. There was generally good clinical engagement and attendance. The clinical centre risk register included most but not all the issues identified as risks during the inspection.

The trust was average for staff engagement when compared with trusts of a similar type. However, the data for medicine showed that staff responded more positively when compared to the Trust average.

There were examples of innovation and improvement.

Vision and strategy for this service

- The trust had a mission, vision and strategy which most staff we spoke with were aware of.
- The medical services were provided through three clinical centres: the Integrated medical care centre, the Speciality medicine centre and the Tertiary services centre. Each of the centres had a managing director, medical and nursing leadership. The leadership of the centres had been fully in place since September 2014.
- The trust had a clear strategic aim to become a dementia friendly organisation "with environments and processes that cause no avoidable harm to patients with dementia". The trust has done a self-assessment, based on the markers of best practice from the National Dementia Audit-Royal College of Psychiatrists, of the environment. An action plan was in place.
- There was significant ongoing work, both strategically and locally on wards to improve the discharge of patients.
- A post had been jointly funded with the local CCG to assess what would be the best medical service model for this hospital.
- There was a clear model of care and development of the CDU and ambulatory services. However a small number of clinical staff commented that the leadership of the trust did not understand the vision of CDU services at the Friarage hospital.

Governance, risk management and quality measurement

- There were monthly governance meetings held for each of the three clinical centres. The service groups, within the integrated medical care centre, each had a clinical governance section on their management agenda and they reported to the Integrated Medical Care Centre Governance Board.
- There were risk registers in place for each of the medical clinical centres which were routinely updated and assessed as well as overarching ones for the whole of medicine. The clinical centre risk register included most but not all the issues identified as risks during the inspection. We were told that the risk registers were not readily accessible for ward managers.
- The head of nursing we spoke with was aware of the risks within the service groups in her clinical centre and what actions were being taken.
- Nurses on the wards told us of incidents where they raised staffing as an issue and this was recorded on the risk register.
- We saw that concerns arising from monitoring of the safety thermometer, complaints and serious incidents were discussed at the care centres' clinical governance meetings. For example, lessons learnt included that the initial falls assessment did not identify all the relevant actions following identification of the risk factors; there was no record of any discussions within patient notes regarding appropriate footwear and; no recording on admission of the impact of ulcers on morbidity. For lessons learnt from pressure ulcers and complaints there was an action log which required evidence of actions being completed before they were signed off. We were told that the head of nursing for the integrated medical care team then met with ward mangers to check if actions had been completed. Risk alerts were routinely shared with staff. They were discussed in ward meetings and made available in folders on the wards for staff.
- There was an action log for lessons learnt from pressure ulcers and complaints. We were told this was to be developed to include falls and medication incidents.
- There was a delayed discharge group which had agreed a number of actions to manage and reduce the number of delayed discharges across the trust. This included an audit of the Patient Status at A Glance (PSAG) boards on each ward to ensure the Boards were used properly to aid planning.
- There were weekly meetings within CDU which were attended by consultants, other medical staff and ward

managers. The meetings reviewed in rotation: incidents, risk, finance, mortality and morbidity data and concerns. We saw evidence of lessons learnt for example a change to the way the medical team handed over to each other as the result of analysing an incident concerning the care of a patient.

Leadership of service

- Staff were generally positive about the leadership. The CDU had strong clinical leadership. Some nursing staff commented that senior nurse leaders for the medical services were not visible and only visited sporadically.
- The senior management team worked closely together. This ensured shared knowledge, robust planning and a cohesive framework for strategic change.
- Healthcare assistant staff felt well supported and comfortable in their role. They felt well trained and able to ask for help if needed.
- We were told about a process of "Discovery interviews" with staff who were given the opportunity to identify what the issues were locally and actions as to how these could be resolved. For example, plans on how to improve the staffing ratio.

Culture within the service

- Staff were very positive about the clinical centres and the service they provided for patients. We observed a supportive rapport between all staff. Different disciplines worked well together and considered each other's needs. Staff appeared to be well motivated.
- Individual complaints were discussed at clinical governance meetings so that learning was shared. Complaints were also reviewed to identify key themes.
- The overall satisfaction of doctors in training was similar to the England average according to the General Medical Council – National Training Scheme Survey.

Public and staff engagement

- The trust sought views from the public through the NHS Friends and Family Test, the response rate was similar to the England average.
- The NHS staff survey 2013 indicted that only three areas out of 29 scored worse than the national average. These were the percentage of staff receiving health and safety training in last 12 months; the percentage of staff feeling pressure in last 3 months to attend work when feeling unwell and; the staff motivation at work score. The overall staff engagement score, 3.74, was similar to other trusts nationally 3.73. Staff at the trust were slightly more likely to recommend the trust as a place to work or receive treatment, when compared with other NHS organisations nationally.
- In the NHS staff survey the staff in the medicine speciality (73%) and acute medicine staff (69%) said they would recommend the organisation as a place to work which was higher than the Trust-wide response of 64%.
- In the NHS staff survey the staff in the medicine speciality (83%) and acute medicine staff (74%) said that if a friend or relative needed treatment they would be happy with the standard of care provided by this organisation compared to the trust average of 75%.
- Each month 20% of the patients who had attended the hospital and were diagnosed with dementia or their relatives were contacted and asked to complete a survey about the care they had received. A recent Board report indicated that that there had been an increase from a base of 52% to 77% for above average or excellent care of the person with dementia.

Innovation, improvement and sustainability

- Staff were aware of the financial challenges that the trust had of the local cost improvement programmes, to ensure sustainability, that were required to achieve these.
- Enhanced observation guidance had been developed to provide a framework for practice to facilitate safe and supportive observation of patients at risk due to their physical or psychological condition. This work was led by a therapeutic nursing sister who had been in place for 18 months.
- A team of therapeutic volunteers had been created to support the enhanced observation guidance. The volunteers had mandatory and dementia training and were in operation 24hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The team had been regionally recognised for its work.
- The HOOT team where the clinical team of the year for their innovative practices. Overnight there were two

senior nurse practitioners (Bands 6 and 7) on duty for the hospital with clinical assessments skills as part of the "HOOT" (Hospital Out of Hours team). These roles helped to assess and respond to any clinical risks overnight.

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Friarage Hospital provided a range of surgical services for the population of Northallerton and the immediate surrounding area and also served the population of Teesside. There were two wards providing surgical services, a surgical assessment unit (SAU), postoperative surgical day unit (POSDU) and surgical theatres providing elective and non-elective treatments.

During this inspection we visited the Allerton Ward, Gara Ward, the SAU and the POSDU. We visited all theatres on-site and observed care being given and surgical procedures being undertaken.

We spoke with 22 patients and relatives and 16 members of staff. We observed care and treatment and looked at care records for 12 patients.

Summary of findings

There were effective arrangements for reporting patient and staff incidents and allegations of abuse. Staff were encouraged to report incidents and received feedback on what had happened as a result. Staffing establishments and skills mix had been reviewed to maintain optimum staffing levels during shifts. Effective handovers took place between staff and included daily safety briefings to ensure continuity and safety of care.

There were arrangements for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment, including the daily checks for anaesthetic equipment.

There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes and had also developed a number of local audits. Mortality indicators were within expected ranges.

Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly to identify patients requiring additional support or to discuss any changes to the care of patients.

We observed positive, kind and caring interactions on the wards and between staff and patients. All patients spoke positively about the standard of care they had

received. All patients we spoke with felt they understood their care options and were given enough information about their condition. There were services to ensure that patients received appropriate emotional support.

Systems were in place to plan and deliver services to meet the needs of local people. Services were available to support patients, particularly those living with dementia, a learning or physical disability. There were also systems in place to record concerns and complaints raised within the division, review these and take action to improve the experience of patients.

There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

The trust's vision, values and strategy were well-embedded with staff and they had a clear understanding of what these involved. Staff were aware of their individual roles and responsibilities and there was effective ward leadership. Staff felt supported at a local level.

Are surgery services safe?

Good

There were effective arrangements for reporting patient and staff incidents and allegations of abuse which was in line with national guidance. Staff were encouraged to report incidents and received feedback on what had happened as a result.

Staffing establishments and skills mix had been reviewed to maintain optimum staffing levels during shifts. Effective handovers took place between staff shift and included daily safety briefings to ensure continuity and safety of care.

There were arrangements for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment, including the daily checks for anaesthetic equipment.

Care records were completed accurately and clearly.

Incidents

- Staff were aware and familiar with the process for reporting and investigating incidents, near misses and accidents using the trust's Datix electronic reporting system. They were also aware of the new statutory duty of Duty of Candour which came in to effect in November 2014.
- Staff told us that they were given feedback on reported incidents and they felt appropriately supported.
- There had been one Never Events in surgery (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) reported at this hospital. We saw this had been fully investigated by the trust, identifying the root causes of the errors, contributory factors, lessons learned, arrangements for sharing learning and actions needed to stop a recurrence.
- Within surgery, 33 serious incidents had been reported in the last 12 months. The reporting of serious incidents was in line with what was expected for the size of the hospital.
- There had not been any grade 3 pressure ulcers recorded on the surgical wards at the Friarage Hospital in 2014.

- Mortality and morbidity meetings were held monthly in all relevant specialties. All relevant staff participated in mortality case note reviews and reflective practice.

Safety Thermometer

- The trust used the NHS Safety Thermometer which is an improvement tool for measuring, monitoring and analysing patient harms and harm-free care.
- Safety Thermometer information was displayed on boards on all wards and theatre areas visited and included information about all new harms, falls with harm, and new pressure ulcers.
- There had been 15 falls reported on surgical wards at the Friarage Hospital between December 2013 and November 2014. This represented 3.1 falls for every 1,000 bed days on the wards.
- All falls assessments were completed within 24 hours at the hospital in October and November 2014. Care records showed that risk assessments were being appropriately completed for all patients on admission to the hospital.
- Records showed there had been 100% harm-free care on the surgical wards between May and November 2014.

Cleanliness, infection control and hygiene

- Wards and patient areas were clean and we saw staff wash their hands and use hand gel between attending to patients. 'Bare below the elbows' policies were adhered to, in line with national recommended best hygiene practice.
- Infection control information was visible in most ward and patient areas.
- All elective patients undergoing surgery were screened for Methicillin-resistant Staphylococcus Aureus (MRSA) and procedures were in place to isolate patients, when appropriate, in accordance with infection control policies.
- There had been no incidences of MRSA during 2014 and two incidences of Clostridium difficile (C. difficile) were reported during April 2014.
- Clinical waste bins were covered with foot-opening controls and the appropriate signage was used for the disposal of clinical waste.
- We saw that separate hand-washing basins, hand wash and hand sanitisers were available on the wards, in theatre and in patient areas.
- Recent reports to the Trust Board showed that the service was compliant with infection control procedures. Infection control audits were completed every month and compliance monitored with key trust policies such as hand hygiene.
- Nursing staff had received training in aseptic non-touch techniques. This encompassed the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- The centre participated in the ongoing surgical site infection audits run by Public Health England. Each case of infection was identified, discussed at formal meetings and actions identified to avoid a repetition.
- Swab, pack surgical instrument and sharp count audits were completed within theatre and these were discussed at divisional meetings with actions identified if required.

Environment and equipment

- We saw that checks for emergency equipment, including equipment used for resuscitation, were carried out on a daily basis.
- Records showed that equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- All freestanding equipment in theatres was noted to be covered and dated when cleaned. Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the wards to ensure safe care.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- We observed that the preparation and administration of controlled drugs was subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Care pathways were in use, including enhanced recovery pathways.
- All wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.

- Care records showed 100% compliance in completing early warning score documentation and undertaking appropriate actions in 2014.
- There was a comprehensive preoperative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act (1998) principles to ensure patient confidentiality was maintained.
- Nursing documentation was kept at the end of the bed, and centrally within the wards, and was completed appropriately.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- We looked at clinical records and observed that all patients had consented in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by all clinical staff responsible for the patient's care and the Mental Capacity Act (2005) associated deprivation of liberty safeguards were referred to the trust's safeguarding team.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take.
- Information provided by the trust (September 2014) showed 64% of staff had completed safeguarding adults training; 78% of staff requiring level one safeguarding for children had completed the training and 60% of staff had completed level two; 78% had completed initial level three training and 83% had completed level three plus training.
- Staff we spoke with were able to describe action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.

Mandatory training

- Performance reports within the division of surgery showed that staff were up to date with most of their mandatory training.
- For example, 89% of staff had attended information governance training, 88% had attended infection prevention and control level 1 and 87% had attended infection prevention and control level 2 training.
- Compliance with mandatory training on the Allerton Ward was 49%; this had been identified as below target and had been given priority by the ward manager.
- Staff we spoke with confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training.
- During group and individual meetings, staff confirmed they felt confident they had received the mandatory training necessary to enable then to perform their role effectively.

Assessing and responding to patient risk

- All wards used an early warning scoring system for the management of deteriorating patients. There were clear directions for escalation printed on the observation charts and staff were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated concerns correctly, and repeat observations were taken within the necessary timeframes.
- Appropriate and robust protocols had been developed in the SAU and the POSDU to ensure patient safety.
- The pre-assessment of patients was in accordance with British Association of Day Surgery guidelines.
- We observed that theatre staff practiced the 'five steps to safer surgery' procedures – an adaptation of some of the steps in the World Health Organization (WHO) surgical safety checklist. Audits across all specialties showed 100% compliance in October 2014. High levels of compliance were evident in previous months during 2014.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken recently by the trust to reassess the staffing levels on wards. This was to ensure that staffing establishments reflected the acuity of patients.
- There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed number.

Surgery

- We reviewed the nurse staffing levels on the wards and theatres we inspected and found that levels were compliant with the required establishment and skills mix.
- Bank or agency staff were not used and staff told us they were asked to cover any staff shortages. The trust's use of bank and agency staff was 0% during 2014, against an England average of 6.1%. The trust had a policy on overtime and agency staff usage.

Surgical medical staffing

- Surgical consultants from all specialties were on call for a 24-hour period and arrangements were in place for effective handovers.
- Patients requiring unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant and the hospital published a rota for the provision of general surgical emergency provision.
- The general surgical on-call team comprised the general consultant and a consultant vascular surgeon.
- Consultants were available on call out of hours and would attend when required to see patients at weekends. Medical staffing within the division was made up of 42% at consultant level (England average 40%), 39% registrar level (England average 37%), middle career 7% (England average 11%), and 11% junior doctors (England average 13%).

Major incident awareness and training

- Business continuity plans for surgery were in place. These included the risks specific to the clinical areas and the actions and resources required to support recovery
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called on to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes and had also developed a number of local audits. Mortality indicators were within expected ranges.

Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly to identify patients requiring additional support or to discuss any changes to the care of patients.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients where appropriate.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for preoperative assessments and these were in line with best practice.
- The surgical care centre and departments took part in all the national clinical audits that they were eligible for. The centre had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- Local audits relating to infection control, checking of controlled drugs and use of personal protective clothing in theatres and recovery showed full compliance.

Pain relief

- Pre-planned pain relief was administered for patients on recovery pathways.
- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.

- All patients we spoke with reported that their pain management needs had been met.

Nutrition and hydration

- Patients were screened using the malnutrition universal screening tool (MUST). Where necessary, patients at risk of malnutrition were referred to the dietician.
- During 2014, 93% of MUST assessments had been completed at the hospital; this figure had increased to 100% during October and November 2014. Appropriate actions had been identified in the care plan and implemented for 100% of patients in the same period.
- Records showed that patients were advised about what time they would need to fast from. Fasting times varied depending on when the surgery was planned, in accordance with trust policy.
- Patient-led assessments of the care environment (PLACE) scored the trust above the England average for food (at 91%, compared to the England average of 90%) in 2014.

Patient outcomes

- There were no current CQC mortality outliers (outside the expected range) relevant to surgery at this trust. This indicated that there had been no more deaths than expected for patients undergoing surgery at this hospital.
- Patient Reported Outcome Measures (PROMs) for hip replacement, knee replacement, groin hernia and varicose vein showed improvements in patients receiving these procedures that were better or similar to the England results.
- Standardised relative readmission rates for elective surgical patients ran higher than the England average (100) for general surgery (132), urology (160) and trauma and orthopaedics (138). For non-elective patients, standardised relative readmission rates ran higher than the England average (100) for general surgery (109) and urology (113) and better than the England average for trauma and orthopaedics (95).
- The trust contributed to all national surgical audits for which it was eligible.
- The National Bowel Cancer Audit (2013) showed better than England average results for clinical nurse specialist involvement (99%, England average 88%), and scans undertaken (97%, England average 89%); 67% of patients undergoing major surgery stayed in the hospital for an average of more than five days (lower than the England average of 69%).
- Lung cancer audit results showed that the percentage of patients receiving surgery (12%) was lower than the England average (16%). The audit showed results better than the England average for multidisciplinary team discussion (100%, England average 96%) and scans undertaken before bronchoscopy (94%, England average 90%).

Competent staff

- Staff told us that appraisals were undertaken annually and records for 2014 showed that the majority of staff across all wards in surgery and theatres had received or arranged an appraisal.
- Although nursing staff said they did not receive clinical supervision or formal one-to-one sessions, informal one-to-one meetings did take place.
- Monthly staff meetings were taking place and minutes were available to staff.
- Junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had received ward-based teaching and were supported by the ward team and could approach their seniors if they had concerns.
- Revalidation of doctors' outcomes were assessed and monitored by the Deanery.

Multidisciplinary working

- Therapists worked closely with the nursing teams on the ward, where appropriate. Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists when needed.
- We observed daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward was planned.
- Staff explained to us that the wards worked with local authority services as part of discharge planning.

Seven-day services

- Daily ward rounds were arranged for all patients, and patients were seen on admission at weekends.

Surgery

- Access to diagnostic services was available seven days a week – for example, x-rays.
- There was an on-call pharmacist available out of hours. Pharmacy staff were available on-site during the week.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw that these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and these were started as soon as possible for patients. Discharge letters were completed appropriately and shared relevant information with a patient's GP.
- During October 2014, 93% of patients had a planned discharge date and 94% of patients had been offered a patient-held checklist on discharge between June and October 2014.
- There were appropriate and effective processes in place to ensure that patient information was coordinated between systems and accessible to staff.

Are surgery services caring?

Good

We observed positive, kind and caring interactions on the wards and between staff and patients. All patients spoke positively about the standard of care they had received.

All patients we spoke with felt they understood their care options and were given enough information about their condition.

There were services to ensure that patients received appropriate emotional support.

Compassionate care

- We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken and listened to promptly. Patients told us staff "…couldn't treat you any better here, so lovely!"
- One person said, "The staff deserve credit where credit is due. It is five-star care. I might be ill but I trust the staff, it's making it easier for me".
- Another patient said, "…the ward is absolutely clean, cleaning never stops. Pre-assessment happened last week and was handled very well. I knew exactly what was happening".
- We observed that staff were attentive to the comfort needs of patients. Patients and relatives were positive about the care and treatment received.
- Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment. We observed patients being kept informed throughout their time within the anaesthetic room and theatres.
- We saw doctors introduce themselves appropriately and draw curtains to maintain patient dignity.

Patient understanding and involvement

- All patients said they were made fully aware of the surgery that they were going to have and this had been explained to them.
- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- Ward managers and matrons were available on the wards so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- The CQC's Adult Inpatient Survey (2013) showed a slight decrease (7.6 in 2013 from 7.7 in 2012) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year.
- There was also a decrease in patients responding positively (6.2 in 2013 from 6.4 in 2012) to say they received answers they could understand when asking important questions to a nurse.

Emotional support

- Patients said they felt able to talk to ward staff about any concerns they had, either about their care, or in general. Patients did not raise any concerns during our inspection.

Surgery

- The CQC's Adult Inpatient Survey showed an increase (7.7 in 2013 from 7.5 in 2012) in patients believing they had received enough emotional support from hospital staff.
- There was information within care plans to highlight whether people had emotional or mental health problems and what support they required for this.
- Patients were able to access counselling services, psychologists and the mental health team.
- Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre- and postoperatively.

Are surgery services responsive?

Good

Systems were in place to plan and deliver services to meet the needs of local people. Staff were responsive to people's individual needs.

Services were available to support patients, particularly those living with dementia, a learning or physical disability, or those whose first language was not English. There were also systems in place to record concerns and complaints raised within the division, review these and take action to improve patients' experience.

There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation policy to deal with busy times.
- Capacity bed meetings were held to monitor bed availability in the hospital; managers responsible for reviewing planned discharge data and assessing future bed availability had been appointed.
- During high patient capacity and demand, elective patients were reviewed in order of priority to prevent cancelled appointments for urgent and cancer patients.

Access and flow

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. Patients requiring assistance from social services on discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- The trust was meeting the referral-to-treatment time targets of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral.
- The referral-to-treatment time for patients admitted from a waiting list and non-admitted patients starting their treatment within 18 weeks of referral was not met within trauma and orthopaedics (74%), urology (88%), ophthalmology (88%), oral surgery (73%) and cardiothoracic surgery (74%).
- The reasons for these shortfalls had been identified and there had been additional recruitment to consultant posts and locum cover arranged to reduce the backlog of patients. The division had also introduced 'three session' days in response..
- Delays to discharge within the trust were caused mainly by patient or family choice (15%), waiting for further NHS non-acute care (24%) or completion of assessment (32%). These are all above the England average (14%, 21% and 19% respectively).
- The average length of stay was below the England average (three days) for all surgical patients (two days) and for general surgery (two days).
- Sixteen patients had their operation cancelled and were not treated within 28 days during 2014; this is higher than the England average during this period and represents a monthly average of 0.53% of elective patients between April and October 2014.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- Suitable information leaflets were available in pictorial and easy-to-read formats and described what to expect when undergoing surgery and postoperative care. We were told these were available in languages other than English but these were not displayed within ward or surgery areas.
- Following discharge we saw that the care of patients was particularly effective through the provision of ongoing physiotherapy services.

- Wards had access to interpreters as required, requests for interpreter services were identified at the pre assessment meeting.
- There was access to an independent mental capacity advocate for when best interest decision meetings were required.
- Compliance with Mental Capacity Act (2005) training varied throughout the centre and areas for focus had been identified, for example, theatres and anaesthetics (40% compliance).

Learning from complaints and concerns

- Complaints were handled in line with the trust policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager and staff were able to explain this process.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service and the mechanisms for making a formal complaint.
- We saw leaflets available throughout the hospital informing patients and relatives about this process.
- Five formal complaints had been received on the hospital's surgical wards during 2014. The ward managers discussed these with us and we were assured these had been handled appropriately in line with trust processes.
- Complaints and concerns were discussed at monthly staff meetings where training needs and learning was identified as appropriate.
- If patients or their relatives needed help or assistance with making a complaint, the Independent Complaints Advocacy Services (ICAS) contact details were visible in the ward and throughout the hospital.

Are surgery services well-led?

Good

The trust's vision, values and strategy were well-embedded with staff and they had a clear understanding of what these involved.

Staff were aware of their individual roles and responsibilities and there was good ward leadership. Staff felt supported at a local level.

Vision and strategy for this service

- The trust's vision and strategy were well-embedded with staff. Staff were able to articulate to us the trust's values and objectives across the surgical wards and the values were clearly displayed on ward areas.
- We met with senior managers who had a clear vision and strategy for the centre and identified actions for addressing any issues. Staff were able to repeat the vision and discuss its meaning with us during individual interviews.

Governance, risk management and quality measurement

- Clinical governance meetings were held each month. Meeting minutes showed complaints, incidents, audits and quality improvement projects were discussed and action was taken where required.
- Reports presented to the Trust Board identified risks throughout the trust, actions taken to address risks and changes in performance. This monitored (among other indicators) MRSA and Clostridium difficile (C. difficile) rates, referral-to-treatment times, pressure ulcer prevalence, complaints, Never Events, complaints and mortality ratios.
- We saw that action plans for Never Events were monitored across the division and sub-groups were tasked with implementing elements of action plans where appropriate.

Leadership of service

- Staff said centre managers were available, visible and approachable. Leadership of the service was good, staff morale was high and staff felt supported at ward level.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience as a priority and everyone's responsibility.
- Nursing staff stated that they were well-supported by their managers.
- Medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.

Culture within the service

- At ward and theatre levels we saw that staff worked well together and with respect between specialties and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.

- Staff were well-engaged with the rest of the hospital. They reported an open and transparent culture on their individual wards and said they felt able to raise concerns.
- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.

Public and staff engagement

- The trust's NHS Friends and Family Test response rate was higher (35%) than the England average (32%) between April 2013 and July 2014 and scores across all areas were similar to the England average during that period.
- The response rates for wards within the surgery division varied between 22% and 89%. The Allerton Ward had a response rate during 2014 of 24%.
- NHS staff survey data (2013) showed that the trust scored as expected in 22 out of 30 areas, and better than expected in five areas.

Innovation, improvement and sustainability

- There were systems in place to enable learning and improve performance which included the collection of national data, audit and learning from incidents, complaints and accidents.
- Evidence showed that staff were encouraged to focus on improvement and learning. We saw examples of innovation such as the development of protocols within the SAU and POSDU, postoperative care and effective admissions and discharge procedures.

Critical care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Friarage Hospital had one integrated intensive care unit (ITU) which was managed under the integrated medical care centre within South Tees Hospitals NHS Foundation Trust. The unit was a modern facility for the care of critically ill patients. The unit covered a catchment population of around 430,500.

The unit had six beds and provided cares for acutely ill patients requiring intensive level 3 care and/or level 2 high dependency care. The maximum number of level 3 patients that could be accommodated at any one time was three. The unit also had facilities for two level 2 high dependency care patients and a side room which could be used for isolation purposes. The unit took patients who have had surgical and orthopaedic elective procedures and require level 2 or 3 care, and acutely ill medical patients.

We visited the ITU and spoke with seven staff, including a consultant, unit manager, nursing staff and physiotherapist, as well as two patients. We also observed care and reviewed documentation, including patient records.

Summary of findings

We rated critical services at this hospital as 'good'. Effective arrangements were in place on the unit for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents, and received feedback on what had happened as a result. Nurse staffing levels were determined using an acuity tool and national guidelines were followed. The complement of medical staff and the skills mix of the medical team were suitable and in line with national guidance. Arrangements were in place for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment and care records were completed accurately and clearly. The unit appropriately assessed and responded to patient risk.

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. The unit performed well in comparison with similar units in terms of patient outcomes, and there were no concerning patient outcome figures. The unit had suitable processes to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams, who met regularly to identify patients requiring visits or to discuss any changes to the care of patients.

Critical care

The team working on the unit were caring, compassionate and patient-focused. We observed positive, kind and caring interactions between staff and patients. Patients spoke positively about the care that they received and felt they understood their care options and were given enough information about their condition. Services were provided to ensure that patients received appropriate emotional support.

The unit was an integrated critical care unit, which meant it could easily flex between level 2 and 3 beds, depending on demand. The staff group were also responsive to the changing needs of patients and worked effectively to manage the workload.

Quality indicators, including early readmissions, late readmissions and post-unit hospital deaths were within acceptable limits on this unit. Average length of stay for all admissions and for patients who survived intensive care treatment were also within acceptable limits. The unit had a very low number of complaints. The vast majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated. Any learning from complaints was disseminated to staff through staff meetings and directorate updates.

Governance processes were embedded and there were appropriate processes for managing risk. The leadership team was approachable and open in its approach, and seen positively by staff. The management team had a number of effective ways of engaging with staff, and patient engagement and feedback was actively sought on the unit.

Are critical care services safe?

Good

Effective arrangements were in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents, and received feedback on what had happened as a result.

Nurse staffing levels were determined using an acuity tool and national guidelines were followed. The complement of medical staff and the skills mix of the medical team were suitable and in line with national guidance.

Arrangements were in place for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment and care records were completed accurately and clearly. The unit appropriately assessed and responded to patient risk.

Incidents

- Between November 2013 and October 2014 the ITU did not record any Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken).
- There had been 35 incidents reported between November 2013 and October 2014 at this hospital. The majority were 'no harm' or 'minor incidents'.
- Nursing and medical staff on the ITU described how they would report incidents and were clear about their responsibilities and who to escalate concerns to. Staff accurately stated that they would report incidents using the electronic incident reporting system.
- Staff were aware of the Duty of Candour regulation introduced in November 2014. Managers, medical and nursing staff stated that this was already intrinsic to their practice. Training and awareness of the new regulation was to be incorporated into the staff induction programme.
- Staff also described how they received feedback about incidents that had been reported. This was mainly through staff meetings. We observed minutes of these meetings which confirmed that incident feedback was given.

- Mortality and morbidity meetings were held weekly on a Wednesday. These meetings were open to all staff, but the majority of attendees were medical staff.
- The ITU team also participated in multi-specialty mortality and morbidity meetings – for example, with medicine – as well as meetings with the critical care unit at the James Cook University Hospital, to promote shared learning.
- The mortality and morbidity meetings were used to provide staff with the opportunity to discuss errors and adverse incidents in an open manner, review care standards and make changes if required.

Safety Thermometer

- The NHS Safety Thermometer is an improvement tool for measuring and analysing patient harms and harm-free care. Information about this was clearly displayed in the ITU.
- Safety Thermometer information included information about all new harms, new pressure ulcers, Methicillin-resistant Staphylococcus Aureus (MRSA) rates and Clostridium difficile (C. difficile) infection rates.
- Between November 2013 and October 2014 the unit had 100% harm-free care for three consecutive months. There was one reported case of MRSA, and none for C. difficile, and pressure ulcer rates varied between two reported in December 2013 to nil in most other months.

Cleanliness, infection control and hygiene

- The general environment and equipment in ITU was visibly clean.
- There was suitable provision of, and access to, hand wash basins and hand gel.
- We observed all staff cleaning their hands when required, using either soap and water or hand gel; this was usually before and after contact with a patient and/or the patient's immediate environment.
- All staff followed the trust's uniform policy in clinical areas and adhered to the 'bare below elbows' principle for best hygiene practice.
- We observed staff, including nurses and designated cleaning staff, clean areas of the ITU. Cleaning schedules were in place and adhered to.
- Clinical waste bins were covered, with foot-operated opening controls. Appropriate signage was used for the disposal of clinical waste.
- Data on unit acquired infection from the Intensive Care National Audit & Research Centre (ICNARC) for 2014 showed no concerning trends in terms of C. difficile or MRSA infections.
- Between November 2013 and October 2014, the ITU had one reported case of unit-acquired MRSA in January 2014, and no cases Methicillin-sensitive Staphylococcus aureus (MSSA) or ventilator-induced pneumonia.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. The unit achieved between 90% and 100% compliance with hand hygiene.
- Records of a recent environmental audit showed that the unit was 100% compliant with infection control procedures.

Environment and equipment

- The environment and equipment were in a good state of repair. There was adequate equipment to ensure safe care.
- Records showed that equipment was serviced by the trust's maintenance team under a planned preventative maintenance programme. This included syringe drivers and ventilators.
- Resuscitation equipment was easily accessible within the unit. We observed that checks for emergency equipment, including resuscitation equipment, were carried out on a daily basis.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- We reviewed two patient records, including drug prescription charts; there were no errors noted.
- We observed medications being administered appropriately.
- A pharmacist from the critical care unit at the James Cook University Hospital reviewed medication every week at this hospital and provided daily advice and support. A pharmacy technician visited this unit every day to review and check medication and referred to a pharmacist of required.

Records

- The healthcare records on the unit were paper-based.

Critical care

- We reviewed two sets of patient records. These were correctly and adequately completed, including core care plans and risk assessments such as venous thromboembolism (VTE or blood clots), moving and handling, pressure area care and nutrition.
- The bedside observation charts on the unit were completed accurately. We noted that staff visiting the unit also completed their sections on the chart as required.

Safeguarding

- Staff on the unit were aware of the trust's safeguarding policies and procedures and could accurately describe the process for reporting concerns about safeguarding.
- Compliance with adults safeguarding level 1 training was 80%. Compliance with children's safeguarding level 1 training was 100% and children's safeguarding level 2 was 78%.
- The unit had an action plan to ensure that all staff received the required safeguarding training by the end of March 2015.

Mandatory training

- Compliance with mandatory training for medical staff ranged between 75% and 100%.
- The highest compliance figures included health and safety, infection prevention and control, patient safety, information governance and equality and diversity training, which were all 100%.
- The lowest compliance figures related to fire safety, moving and handling and Mental Capacity Act (2005) training, which were all at 75%.
- Compliance with mandatory training for nursing staff ranged between 50% and 100%. The overall compliance rate was 83%.
- The highest compliance figures included infection prevention and control (100%), fire safety (92%), health and safety (84%), and Mental Capacity Act training (83%).
- The lowest compliance figures related to basic life support (50%) and moving and handling (52%).
- The unit had an action plan to ensure that all staff received the required mandatory training by the end of March 2015.

Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS) system for acutely ill patients and this supported the process for early recognition of those patients who were deteriorating and required prompt medical assessment or intervention.
- All patients on the ITU were monitored closely and no concerns were raised in terms of the responsiveness of staff in reacting to the deteriorating patient; this included gaining prompt access to medical intervention.
- Management of the deteriorating patient was supported by a critical care outreach team. This service was available every day between 8am and 6pm. This was to be extended to 8pm. A medical nurse practitioner provided support overnight.
- The outreach team also reviewed, at least once, all patients who were discharged from critical care services back onto the ward.
- We spoke with the unit manager and a member of the outreach team; the critical care outreach team followed up patients discharged from ITU to the ward; no significant concerns were raised about how outreach functioned or about risks to patients.
- Between January and July 2014, the team had received around 100 inpatient ward referrals.

Nursing staffing

- Nurse staffing levels were determined using a trust-wide staffing acuity tool and the Core Standards for Intensive Care Units 2013 were followed to decide the numbers of nursing staff required for each patient; this included the requirement to have two-to-one care for level 2 patients and one-to-one care for level 3 patients.
- The trained nursing establishment for the unit was 18.28 whole time equivalent (WTE). This included 0.8 band 7 unit manager, 6.18 WTE band 6 clinical sisters and 8.82 WTE band 5 nurses.
- The 0.8 band 7 unit manager was supernumerary and acted as a clinical coordinator while on duty. The other band 6 clinical sisters also completed this role. This was in line with the Core Standards for Intensive Care Units 2013.
- The unit was just under the ideal staffing complement for band 5 nurses and there was a 1.71 WTE vacancy in this band. This post was being actively recruited at the time of the inspection.

- The unit had 0.8 WTE band 3 healthcare assistant and 0.31 WTE band 2 healthcare assistant. The acuity tool used on the unit showed a deficit in the ideal staffing complement for healthcare assistants. The unit had a business case in progress to rectify this.
- Any shortfalls in nurse staffing levels were addressed by existing staff working additional hours as overtime or flexible working.
- Bank and agency staff were not used on the unit.
- Two nurse handovers took place each day. The handover included basic clinical information about patients and allocating patients to incoming staff prior to their shift commencing.

Medical staffing

- The complement of medical staff and the skills mix of the medical team were suitable and were in line with national guidance.
- There were four consultant grade doctors, as well as junior doctors.
- Out of hours there were 10 anaesthetic consultants who covered ITU and emergencies and an anaesthetic trainee resident overnight of core training 2 plus level.
- The number of junior doctors varied; the ones we spoke with were positive about their learning and development on the unit.
- Medical handovers, including those led by a consultant, were reported to be sufficiently detailed and comprehensive.
- Consultants did not work in five-day blocks; this was not in line with Core Standards for Intensive Care Units 2013. Instead, consultants covered out of hours for 24-hour blocks throughout the week. Both medical and nursing staff stated that there were no problems with continuity of care due to this arrangement.
- Patients were reviewed by a consultant within 12 hours of admission to the unit, including at weekends. Patients were then medically reviewed by a consultant at appropriate intervals, again including at weekends.
- The non-consultant-grade doctors and the nurses we spoke with felt that the cover arrangements and working patterns of the medical team were suitable; this included the access to a consultant out of hours, including at weekends.
- The consultant-to-patient ratio was in line with that recommend in national guidance. The unit did not use any locum doctors.

Major incident awareness and training

- There was a major incident policy and a business continuity plan for the unit. These were accessible to staff.
- Staff we spoke with were aware of these policies and plans and how to escalate issues during emergency situations.
- The unit had taken part in telephone exercises and scenarios as part of major incident planning.

Are critical care services effective?

Good

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. The unit performed well in comparison with similar units in terms of patient outcomes, and there were no concerning patient outcome figures.

Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams, who met regularly to identify patients requiring visits or to discuss any changes to the care of patients.

Evidence-based care and treatment

- We reviewed a selection of policies on the unit's intranet and out on the unit; they were based on up-to-date evidence, including guidance from the National Institute for Health and Care Excellence (NICE), relevant royal colleges and core standards for ITUs.
- There were a number of examples where practice was supported by evidence-based guidance, including how patients were rehabilitated (which was in line with NICE guideline 83, Rehabilitation after critical illness), the use of care bundles, and a quality improvement project to reduce bloodstream infections.
- In monitoring adherence to local policies and procedures, we saw evidence of local audits for pressure sores, central lines, nutrition and blood transfusion.
- We saw evidence of changes in practice because of local audit activity. For example, an audit correlating sleep quality and ward noise levels resulted in the introduction of rest periods and slow-closing bins.

- Of the patient charts and care plans we reviewed, there was evidence of decisions being made in line with national standards, for example, nutrition, pain, nasogastric tube placement and fluid management and hydration.

Pain relief

- The unit had access to a dedicated acute pain team.
- We reviewed two patient charts and noted that pain scores were appropriately recorded.
- We also observed pain scores being discussed during ward rounds.
- Patients we spoke with confirmed that their pain management needs had been met.

Nutrition and hydration

- All patients had a malnutrition universal screening tool (MUST) assessment on admission to the ITU or high dependency unit. The MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese.
- We reviewed two patient records and noted that accurate and up-to-date nutritional assessments using the MUST.
- The unit had input from a dietician (0.1 to 0.12 WTE) three times a week. The Core Standards for Intensive Care Units 2013 state that there should be one WTE dietician for every two patients. To help address this shortfall, the service, in conjunction with dietetics personnel, had developed an algorithm to support referral and feeding regimes to maintain patients' nutritional status.

Patient outcomes

- We reviewed the data from the ICNARC audit for October 2013 to March 2014.
- There were no areas for concern in relation to quality indictors at admission, this included in-hospital cardio-pulmonary resuscitation (CPR), MRSA and C. difficile. This was also true for ventilated admissions, admissions with sever sepsis and admissions with pneumonia.
- Figures for unit-acquired infections per 100 and per 1000 admissions were within acceptable ranges.
- In relation to outcomes and delivery of care, the data was positive in comparison to other similar units. This was true for out-of-hours discharges, out-of-hours discharges to the ward, delayed discharges and delayed discharges (four-hour delay).
- In contrast, early reported discharge numbers between 2009 and 2014 were predominantly higher than that of other similar units.
- There were no significant concerns, and unit mortality figures were within acceptable ranges; trends in mortality were consistently below that of other similar units.
- There were no ongoing or reported CQC outliers (services lying outside the expected range of performance).
- Between January and July 2014, there were no critical care discharges readmitted to the unit within 48 hours of discharge to wards.

Competent staff

- All critical care consultants had an up-to-date appraisal and all had, or were undergoing, revalidation.
- Newly appointed consultants would not be part of the medical on-call rota for their first month, and all would be required to complete the trust's induction programme.
- New consultants would not be required to work autonomously for their first month.
- Any trainee doctors would be training specifically in anaesthesia and intensive critical care medicine.
- 78% of nurses had received an appraisal. The unit had an action plan in place to ensure that all staff received an appraisal by the end of March 2015.
- Staff described opportunities for clinical supervision which included reflecting on practice and discussing issues at staff meetings.
- All band 5 nurses completed a supernumerary induction and were assessed using the National Competency Framework for Adult Critical Care Nurses.
- Half of the total number of nurses on the unit had a post-registration qualification in critical care. This was in line with Core Standards for Intensive Care Units (2013).

Multidisciplinary working

Critical care

- We observed good multidisciplinary team working; the unit had positive input from a range of healthcare professionals including doctors, nurses, physiotherapists, dieticians, pain nurses, speech and language therapists and a microbiologist.
- Most of these healthcare professionals were present during ward rounds, which meant that there was a holistic approach to patient care.
- All patients discharged from the unit to wards had at least one follow-up visit from the critical care outreach team.
- The critical care outreach team was accessible every day between 8am and 6pm. This was to be extended to 8pm. A medical nurse practitioner provided support overnight.

Seven-day services

- Consultant presence on the unit in daytime met the recommended levels of intensive care medicine programmed activities.
- Both in- and out-of-hours junior doctor cover was at safe levels. The skills mix was suitable to cover emergencies, including airway emergencies.
- Out-of-hours cover during the week was provided by a consultant with sufficient intensive-care medicine experience, as per core skills requirements.
- Staff, including nurses and trainee-grade doctors, said that on-call consultants were approachable and would come in from home if necessary.
- Access to x-ray facilities was available 24 hours a day, seven days a week.
- Physiotherapy services were provided daily, including on Saturday and Sunday; physiotherapy had an on-call service for urgent matters.
- Pharmacy services provided a daily service as well as an on-call service for advice. There was access to an emergency drug cupboard if required.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw that these were available to staff, enabling effective care and treatment.
- There were appropriate and effective systems in place to ensure patient information was coordinated between systems and accessible to staff.

Consent and Mental Capacity Act and deprivation of liberty safeguards

- Opportunities for gaining written and/or verbal consent from patients on the ITU were limited due to the severity of some patients' conditions and the fact that many patients were sedated or unconscious.
- Staff reported that much of the care provided to patients was in their best interests and how, for some medical interventions, the patient's family and/or friends would be consulted.
- We observed examples where specific consent had been gained from a person's family; this related to fitting a tracheostomy.
- In relation to the Mental Capacity Act (2005) and its associated deprivation of liberty safeguards, nurses we spoke with accurately explained the process for providing care where these issues needed to be considered.
- Staff had received Mental Capacity Act (2005) training and, at the time of the inspection, 75% of medical staff and 83% of nursing staff had completed this training.

Are critical care services caring?

Good

The team working on the unit were caring, compassionate and patient-focused. We observed positive, kind and caring interactions between staff and patients. Patients spoke positively about the care that they received.

Patients we spoke with felt they understood their care options and were given enough information about their condition. Services were provided to ensure that patients received appropriate emotional support.

Compassionate care

- We observed interactions between patients and staff, and staff were always polite, respectful and professional in their approach. We observed patients being treated with compassion, dignity and respect.
- We spoke with two patients during the inspection; both felt well-informed about their care and treatment. Patients expressed no concerns about the care provided and they felt that staff were caring in their approach.

- Patient feedback was available on an information board at the entrance of the unit. The feedback we saw was very positive.

Understanding and involvement of patients and those close to them

- Patients felt involved in their care and had been given the opportunity to talk to their medical team.
- The unit manager and nursing staff were available on the unit so that relatives and patients could speak with them.

Emotional support

- There was access to counselling services.
- The trust arranged an annual event for patients discharged from critical care services at both this hospital and the James Cook University Hospital which gave patients an opportunity to discuss their experiences of the unit.
- Multi faith services were available.
- All patients in ITU had a delirium score and were placed on a specific delirium pathway if required.

Are critical care services responsive?

Good

The unit was an integrated critical care unit, which meant it could easily flex between level 2 and 3 beds, depending on demand. The staff group were also responsive to the changing needs of patients and worked effectively to manage the workload.

Quality indicators, including early readmissions, late readmissions and post-unit hospital deaths were within acceptable limits on this unit. Average length of stay for all admissions and for patients who survived intensive care treatment were also within acceptable limits.

The unit had a very low number of complaints. The vast majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated. Any

learning from complaints was disseminated to staff through staff meetings and directorate updates.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation policy to deal with issues of concern. It also had a surge policy and procedure to deal with busy times.
- The unit worked closely with the critical care unit at the James Cook University Hospital in terms of staff cover and escalation procedures for bed capacity issues.
- There were discussions in progress with the trust's executive team to look at the options for opening an additional level 3 bed in the unit to help with capacity issues.

Meeting people's individual needs

- The unit was responsive to the needs of patients with complex needs, which included people living with dementia and specific learning needs.
- Staff we spoke with described how, in such cases, patients' carers and/or family members were valued in supporting nurses providing care and support. The unit had flexible visiting hours for relatives when a patient needed extra support.
- Specific leaflets were available for patients, with information about the ITU and what to expect of critical care.
- Translation services were available and staff could describe the process for accessing these services.

Access and flow

- Bed occupancy for adults at this trust tended to be slightly above the England average. Between November 2013 and November 2014 the average occupancy of this unit was 78%. Occupancy was lowest in January 2014 at 60% and highest in October 2014 at 85%.
- National guidance advocates that an acceptable bed occupancy percentage is between 80% and 85%.
- We reviewed the data from ICNARC for October 2013 to March 2014.
- In relation to quality indicators, including early readmissions, late readmissions and post-unit hospital deaths, these were within acceptable limits.
- Patient transfers out had consistently been just above the average for other similar units between 2009 and 2014.
- The data for average length of stay for all admissions and for unit survivors were within acceptable limits.
- Between October 2013 and October 2014, three operations were cancelled due to no available ITU beds at this hospital.

Critical care

Learning from complaints and concerns

- The ITU had a very low number of complaints. The vast majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated.
- Complaints were reported at the directorate monthly clinical governance meetings.
- Learning from complaints was disseminated to staff through staff meetings and directorate updates.

Are critical care services well-led?

Good

Critical care services were well-led at this hospital. The trust's values and objectives had been communicated to all staff and those we spoke to had a clear understanding of what this involved. Governance processes were embedded and there were appropriate processes for managing risk.

The leadership team was approachable and open, and seen positively by staff. The management team had a number of effective ways of engaging with staff, and patient engagement and feedback was actively sought on the unit.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation, with clear aims and objectives. The trust's values and objectives had been communicated to the unit and were visible in staff areas.
- Staff had a clear understanding of what this involved and most were able to discuss the vision during individual conversations.

Governance, risk management and quality measurement

- The unit participated in monthly clinical governance meetings where complaints, incidents, audits and quality improvement were discussed.
- Feedback from these meetings was given at staff meetings.
- A risk register was in place for the ITU. This had controls and assurance in place to mitigate risk.

Leadership of service

- From our observations and speaking with staff, including the management team, and reviewing the systems and processes in place on the unit, we found that the leadership on the unit was effective and seen positively by staff.
- Senior nurses, consultants and managers had good visibility on the unit and were well-known to staff.
- The leadership team was approachable and open.

Culture within the service

- Staff worked well together and there was respect between disciplines. We saw good team working on the unit between staff of different grades and disciplines.
- Staff were well-engaged with the rest of the hospital and reported an open and transparent culture on the unit. They reported good engagement at unit level and felt that they were able to raise concerns and that these would be acted upon.
- Staff spoke positively about the service provided for patients. High-quality, compassionate care was seen as a priority.

Public and staff engagement

- The management team had a number of effective ways of engaging with staff, including formal staff meetings, informal discussions at handover, and by having a strong presence on the unit.
- Information about the unit, including details of incidents and minutes of meetings, were all accessible to staff. Information was openly shared and discussed between all levels of staff.
- Patient engagement was actively sought on the unit. Feedback from this engagement was displayed on an information board at the entrance of the unit. This engagement was very positive.

Innovation, improvement and sustainability

- Managers and staff told us that they were supported to try new ways of working to improve the effectiveness and efficiency of the unit.

Maternity and gynaecology

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Outstanding
Overall	Good

Information about the service

Following a reconfiguration of maternity services in October 2014, the maternity service at the Friarage Hospital became a separate, midwifery-led unit. It provided care for pregnant women who were medically fit, had a normal pregnancy and were at low risk of complications. Women identified as high-risk were transferred to the James Cook University Hospital for consultant-led care.

The unit worked on a semi-integrated model between community and unit-led care. There were five labour ward rooms. Since opening on 6 October 2014, there had been 46 births at the Friarage Hospital. The unit was previously dealing with 1,300 births per annum.

We visited the antenatal clinics, labour ward and early pregnancy assessment unit. We spoke with two women and four midwives, a midwifery support worker and the head of midwifery. We observed care and treatment and looked at two care records. We also reviewed the trust's performance data.

Summary of findings

Overall, maternity services were good in all areas with an 'outstanding' rating for leadership. The service provided safe and effective care in accordance with recommended practices.

Resources, including equipment and staffing, were sufficient to meet women's needs. Staff had the correct skills, knowledge and experience to do their job.

The individual needs of women were taken into account in planning the level of support throughout their pregnancy. Women were treated with kindness, dignity and respect while they received care and treatment.

The maternity services were led by a highly committed, enthusiastic team of staff, each of whom shared a passion and responsibility for delivering a high-quality service. Governance arrangements were embedded at all levels and enabled the effective identification and monitoring of risks and the review of progress on action plans. There was strong engagement with patients and a focus on gaining greater involvement from patients groups who represented the local population using the service.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

Effective systems were in place for reporting, investigating and acting on adverse events. Information was routinely collected and reviewed around standards of safety and shared with staff.

Staffing levels were set and reviewed at ward and board levels using nationally recognised tools and guidance. Midwifery staffing was in line with national recommendations for the number of babies delivered on the unit each year.

Care and treatment was planned and delivered in a way to ensure women's safety and welfare. Staff followed safety guidance for infection prevention and control. Medicines were managed safely. Records relating to the care of women were detailed enough to identify their individual needs and to inform staff of any risk and how these were to be managed.

Incidents

- Trust policies for reporting incidents, near misses and adverse events were embedded in maternity. All staff we spoke with said they were encouraged to report incidents and were aware of the process to do so. Incidents were reported on the trust's electronic incident-reporting system. Staff told us they always received feedback about incidents they had reported, with outcomes of any investigations.
- There were a number of internal communication methods used to inform staff of learning and changes to practice. This included a monthly obstetric risk management newsletter, Risky Business, emails and staff supervision. Staff could attend multidisciplinary meetings held at James Cook University Hospital to discuss incidents or interesting cases from the previous 24-hour admissions.
- Perinatal mortality and morbidity cases were discussed at audit and monthly multidisciplinary team meetings which were attended by obstetric and paediatric staff.

Safety Thermometer

- The NHS Safety Thermometer was in use at the unit and the information was displayed in clinical areas for patients and relatives to view. There had been no patient harms since October 2014.

Cleanliness, infection control and hygiene

- All areas we visited had antibacterial gel dispensers at the entrances. Appropriate signage was on display regarding hand-washing for staff and visitors.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking to ensure they were managed on the correct care pathways.
- Cleaning services were commissioned with external contractors. Cleaning schedules showed that staff followed required cleaning practices and the frequency of cleaning.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when required, and they adhered to 'bare below the elbow' guidance in line with national good hygiene practice.
- A trust-wide environmental audit (October 2014) showed the service was compliant with trust targets.

Environment and equipment

- There was adequate equipment on the wards to ensure safe care – specifically cardiotocography (CTG) and resuscitation equipment. Staff confirmed that they had sufficient equipment to meet patients' needs.
- The service used a CTG training tool to assess staff competence and awareness of the functionality of CTGs. For example, checks were performed to ensure the date and time on the CTG was accurately set and that all necessary equipment was available to monitor the foetal heart rate.
- Maintenance of equipment was regularly checked by the trust's medical engineering department and records showed that staff carried out equipment checks each day.
- There was one birthing pool in the unit. Staff had received training in the use of the evacuation sling to ensure the safest method of removing the woman from the pool in an emergency.

- The midwifery-led unit provided a comfortable, relaxed environment for women and their partners. The design was able to ensure that women and babies were kept safe and could be transferred quickly in an emergency. There was also provision for partners to stay overnight.

Medicines

- There were no controlled drugs kept in the unit. The unit did not use opioids. Medicines that required storage at a low temperature were stored in a specific medicines fridge. All of the fridge temperatures were checked and recorded daily. There were no gaps in recording.
- Midwives told us they received support from the on-site pharmacist when required.

Records

- Clinical records were completed to a high standard. Each record we looked at contained a clear pathway of care which described what women should expect at each stage of their labour. When not in use, records were kept safe in line with the data protection policy.
- Risk assessments were completed at booking and repeated at every antenatal visit.
- Women carried their own records throughout their pregnancy and postnatal period of care. The child health 'red book' (showing records of routine tests and vaccinations) was given to women prior to the newborn examination, and it was completed correctly.
- The maternity service used approved documentation for the process of ensuring all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.
- Standard operating procedures and care pathways were included in records for care of women with diabetes, epilepsy, hypertension or a high body mass index (BMI) in pregnancy.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated, full-time midwife responsible for safeguarding vulnerable adults who liaised with multi-agency safeguarding teams across the catchment areas.
- Risk assessments and clear pathways of care were in place to identify women and children at risk. Electronic reminders alerted staff to check for any previous history, such as parenting capacity, health needs and family and environment. The service had developed a joint antenatal pathway with health visitors where any vulnerability or safeguarding concern was highlighted at an early stage and an in-depth, joint midwife and health visitor appointment was arranged.
- Staff had a good understanding of the need to ensure that vulnerable people were safeguarded and understood their responsibilities for identifying and reporting any concerns. The safeguarding lead told us all midwives received annual safeguarding training and community midwives also attended a 1.5 hour refresher course every 12 weeks.
- Records showed that 100% of staff had completed level 1 adult and childrens safeguarding training, 83% level 2 and 100% level 3.
- There were appropriate security measures in place. Security was discussed with women antenatally, during their stay in hospital and recorded in the medical notes. A child abduction critical response plan set out actions to be taken by staff.
- Staff were aware of the possibility of female genital mutilation (FGM) and were working within the Department of Health multi-agency guidelines which included general information about FGM and the best practice to follow in all cases.

Mandatory training

- Midwifery staff attended a three-day obstetric mandatory programme which included emergency drills, adult and neonatal resuscitation, infant feeding, record-keeping and risk management awareness. Emergency drill training was also facilitated on an annual, one-day obstetric mandatory training day for maternity support workers. In addition, bi-monthly emergency drills were facilitated on both sites, through the use of structured drill programmes.
- All attendance at training provided by the maternity service (including CTG training) was monitored by the clinical training and education midwife who maintained a database of attendance. Any staff member who failed to attend three months after the due date, despite reminder letters, was referred to their line manager or educational supervisor.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool known as the Maternal Early Warning System to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to

identify and respond with additional medical support if required. The records we reviewed contained completed scores for women who had been identified as at risk. An audit for October 2014 showed that all Maternal Early Warning System charts had been completed correctly.
- There were clear processes in the event of maternal transfer by ambulance. Staff told us the on-call midwife would also come if a transfer was planned.
- The unit used the 'fresh eyes' approach – a system that required two members of staff to review foetal heart tracings. Staff had also developed the 'fresh ears' system for two-hourly foetal auscultation (second listener to listen to foetal heart to ensure correct recording and early detection of concerns) which indicated a proactive approach in the management of obstetric risks.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG) guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:27 (midwives to patients) against the RCOG recommended ratio of 1:28.
- Daily staffing levels for the unit were two midwives and one healthcare assistant. A third community-based midwife was on duty Monday to Saturday from 9am to 5pm. Outside of these hours, a midwife was on call. There were 13.8 whole time equivalent (WTE) community midwives working in the area of the Friarage Hospital. The head of midwifery told us that the staffing numbers and skills mix had remained the same following the reconfiguration of services.
- An acuity tool was used to assess workload. Staffing levels and skills mix were reviewed each month by the head of midwifery and managers. There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster. The service was innovative in managing workloads and could utilise staff flexibly – for example, an extra midwife was on call if a home birth or transfer was planned.
- Briefing boards were used and verbal handovers occurred between midwives at the patient's bedside.

Medical staffing

- The unit at the Friarage Hospital was solely midwifery-led, with no intrapartum consultant input. Any women who were identified as high risk were transferred to James Cook University Hospital for consultant-led care.
- Consultant medical staff provided weekly maternal, foetal medicine and gynaecology clinics. The maternity day unit (MDU) runs 9-5 Monday – Friday allowing open access to immediate. The MDU can access medical staffing support.

Major incident awareness and training

- Business continuity plans for maternity were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were clear escalation processes to activate plans during a major incident or internal critical incident, such as shortfalls in staffing levels or beds shortages.
- Midwives undertook training in obstetric and neonatal emergencies at least annually. The head of midwifery told us that extra emergency drills were undertaken prior to the reconfiguration of the service to ensure the safe transfer of women in an emergency to James Cook hospital.
- The trust had major incident action cards to support the emergency planning and preparedness policy. Staff in maternity were aware of the policy and understood their roles and responsibilities.

Are maternity and gynaecology services effective?

Good

The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits. Information about patient outcomes was routinely monitored and action was taken to make improvements.

Staff had the correct skills, knowledge and experience to do their jobs. Midwifery staff received training to deliver their roles effectively, and they had been supervised and supported to maintain their competencies and professional development.

Maternity and gynaecology

Multidisciplinary working was good between hospital and community services. Support from allied healthcare professionals and specialist expertise was available to women using maternity services.

Evidence-based care and treatment

- There was evidence to demonstrate that women using maternity services were receiving care in line with National Institute for Health and Care Excellence (NICE) quality standards for routine antenatal care (no. 22), caesarean section (no. 32) and postnatal care (guidance no. 37).
- Staff were consulted on guidelines and procedures which were regularly reviewed and amended to reflect changes in practice. Policies and procedures were available on the trust's intranet and were ratified by the obstetric risk management group. The policies we reviewed (postpartum haemorrhage, multiple births, pre-eclampsia and raised blood pressure) were all in date and in line with best practice. The clinical audit lead told us that all guidelines were audited three months after being introduced and action plans were implemented and monitored as required.
- The service had a dedicated cross-specialty research team which included a research midwife. The team received additional training in good clinical research practice to ensure that research studies were run ethically, safely and effectively.
- Staff told us there was a robust audit cycle. There were ongoing audits for rates of third-degree tears, post-partum haemorrhage, infection control, transfers from the midwifery-led unit to consultant care, breastfeeding initiation and many more areas.
- We saw from audit reports and presentations that a wide range of improvements and changes had been made to enable best practice. Examples included: launch of a health and wellbeing webpage; tools to support discussions about diet and exercise postnatally; and changes to clinical practice and guidelines.

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Pain relief

- Detailed information was given to women to make them aware of the pain relief options available to them. Pain relief was provided using drug-free methods and complementary therapies. The service had access to a hypno-birthing midwife who provided a birth education programme teaching women simple self-hypnosis, relaxation and breathing techniques for a better birth. There was also access to aromatherapy during pregnancy and birth.
- If a woman decided she needed an epidural, she would be transferred to the James Cook University Hospital.
- Trust data showed that 13% of women had delivered with simple analgesia such as paracetamol and codeine.
- Clinical records showed that pain assessment charts were completed at least four-hourly or following any pain-related intervention.

Nutrition and hydration

- There was a specialist midwife for infant feeding, with a lead role in supporting and improving infant feeding and nutrition across the service. The service also had 30 maternity care assistants and 20 voluntary peer supporters working at the hospital and in the community who advised and supported breastfeeding women.
- The service was participating in the biological nurturing 'laid-back breastfeeding' philosophy which adopted approaches to enable a baby's natural response to breastfeed in a number of positions or behavioural states.
- Friarage Hospital had achieved stage 2 in the United Nations Children's Fund (UNICEF) Baby Friendly Initiative accreditation scheme and was being assessed for stage 3 in January 2015.
- Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements. Women we spoke with said the quality of food was good.

Patient outcomes

- Since opening on 6 October 2014, the unit delivered 46 babies. The unit was previously dealing with 1,300 births per annum.
- Trust data for the Friarage midwifery-led unit showed that 9.5% of women had been transferred to James Cook University Hospital in the postnatal period, compared to 81% of women who did not require transfer. The head of midwifery told us all transfers were recorded on a database, monitored and reviewed. All transfers were also reported to the clinical commissioning groups.

Competent staff

Maternity and gynaecology

- We found that staff had the correct skills, knowledge and experience to do their jobs.
- The maternity service training strategy ensured timely provision and monitoring of specialist training for all staff, in line with national guidance. (Centre for Maternal and Child Enquiries, 2011. Saving Mothers' Lives:Reviewing maternal deaths to make motherhood safer: 2006-2008, and NICE guidance).
- All midwives had a named supervisor of midwives. The team of supervisors were experienced midwives from a variety of clinical and managerial backgrounds. They were clearly committed, innovative and hard working.
- Supervisors of midwives were available seven days a week and on call out of hours. Supervisors were clearly visible and had caseloads of 1:15 which was in line with the local supervising authority recommendations. Midwives said they had received a supervisory review and were aware of how to contact their supervisor if required.
- As part of the supervisory review, all midwives provided a written piece of reflective practice which included areas for personal development to discuss with their supervisor.
- All third year student midwives met with their named supervisor to discuss the supervisory annual review, which was good practice.
- A comprehensive 18- to 24-month preceptorship practical experience and training programme was undertaken by newly registered midwives. Following successful completion of goals and competencies, midwives gained automatic progression to a high job banding.
- Staff from the Friarage Hospital worked at James Cook University Hospital on a rotational basis. The head of midwifery told us that, as a minimum, staff rotated for four weeks every two years. The service was looking to increase this to six months every two years.
- There was a designated lead for antenatal screening. Screening tests offered followed the guidance of the UK National Screening Committee (for antenatal and newborn screening).

Multidisciplinary working

- There was good multidisciplinary team working. All necessary staff, including those in different teams and services, were involved in the assessment, planning and delivery of women's care and treatment. The service participated in regional and local multidisciplinary team networks in areas such as foetal medicine.
- Staff told us they worked closely with James Cook University Hospital to ensure the safe transfer of women in an emergency.
- There was access to medical care for women who had other conditions. Joint clinics were held for diabetes, cardiology and mental health.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or risks of child protection.

Seven-day services

- The midwifery-led unit was open 24 hours, seven days a week.
- Access was available to pharmacy and diagnostic services. The service acknowledged its risk of non-compliance with NICE guidance to provide a seven-day early pregnancy ultrasound service. Action had been taken, with the appointment of additional sonographers who were in the process of completing their year's training.
- There was a designated physiotherapist for women's health who provided advice and exercise programmes for women with pelvic pain during pregnancy.

Access to information

- Failsafe systems were in place to ensure appropriate tests were undertaken when women booked late. For example, reminders were sent at 28 weeks to women who declined HIV testing. There was a process for the review of results and reporting these to women and other relevant healthcare professionals.
- During the transfer of women, there were processes to ensure that all appropriate documentation and case notes travelled with the woman, along with results of the appropriate investigations carried out.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Women confirmed they had been given sufficient information to help in making decisions and choices about their care and the delivery of their babies.

- Staff had a good understanding of mental capacity and described the process to care for women with special needs. The community midwife made arrangements via the needs coordinator and care plans were arranged accordingly.

Are maternity and gynaecology services caring?

Good

Staff provided compassionate care and emotional support to women and their partners. Women felt involved in their care; they understood choices open to them and were given options of where to have their baby. Women were treated with dignity and respect.

Compassionate care

- Women spoke positively about their treatment by staff and the standard of care they had received. Women told us they had a named midwife. They felt well-supported and cared for by staff, and their care was delivered in a professional way.
- Results of the NHS Friends and Family Test showed that most respondents were 'extremely likely' or 'likely' to recommend the service to friends and family. The antenatal response rates for the trust were below the England average for antenatal, postnatal and birth scores. The matron was proactively promoting patient experience projects, including the NHS Family and Friends Test which included a feedback card and envelope system to improve response to community questions.
- We observed staff interacting with women and their relatives in a polite, friendly and respectful manner. There were arrangements in place to ensure privacy and dignity in all clinical areas.
- Maternity services scored about the same as the England average for the time taken for staff to respond to call bells.
- Company representatives visited the postnatal area daily. They liaised with ward staff to check if it was appropriate for women to be visited. This ensured women's privacy and dignity was respected.

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth at booking and throughout the antenatal period. Women we spoke with said they had felt involved in their care; they understood choices open to them and were given options of where to have their baby.
- Women were encouraged to visit the maternity unit in person or look at the website for a virtual tour to familiarise themselves with the facilities before deciding where they wanted to give birth.
- The rate of home births was 1.5%. Records showed that staff discussed birth options at booking and during the antenatal period. Supervisors of midwives were also involved in agreeing plans of care for women making choices outside of trust guidance, focusing on supporting women's choices of birth while ensuring they were making fully informed decisions.
- There was a range of information leaflets in clinical areas, including tests and screening, breastfeeding and other sources of support. Information was available in different languages if required.
- The unit was developing 'early bird' sessions run from clinics which provided information to women prior to formal booking.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; this was facilitated by a senior midwife with a special interest in the care of the bereaved and a bereavement support worker who worked closely with the chaplaincy service.
- Women using the maternity services could access clinical nurse specialists for antenatal screening, diabetes, substance misuse and infant feeding.
- There were effective processes to support women with mental health concerns. A comprehensive, evidence-based maternal mental health referral algorithm was used for antenatal and postnatal care. (NICE clinical guideline 45, Department of Health maternal mental health pathway 3). The assessments were carried out at booking and following birth, before hospital discharge. Referrals could be made to the consultant or community psychiatric nurse in perinatal psychiatry.

Are maternity and gynaecology services responsive?

Maternity and gynaecology

Good

The service was aware of risks to ensure that services were planned and delivered to meet increasing demands. There was good access to clinics. Women we spoke with said they did not have to wait long before being seen.

Facilities in maternity were set up in a manner which enabled staff to be responsive to the needs of women and their families. There was access to investigation, assessment, treatment and care at all stages of the maternity pathway. Where women had additional healthcare-related needs, there was access to specialist support and expertise.

Women using the service could raise a concern and be confident this would be investigated and responded to.

Service planning and delivery to meet the needs of local people

- The service was aware of its risks to ensure services were planned and delivered to meet the increasing demands of the local and wider community. It worked closely with local commissioners of services, the local authority, other providers, GPs and patients to coordinate and integrate pathways of care that met the needs of the local population. For example, the service had close links with the Ministry of Defence and worked in partnership with them to provide medical care to women. An additional antenatal clinic was held at the Catterick Garrison in North Yorkshire.
- Services were planned and delivered to enable women to have the flexibility, choice and continuity of care wherever possible. The head of midwifery told us the service was actively promoting the normality agenda in pregnancy, with the aim to be a central hub for midwifery-led care.
- The service worked closely with the maternity services liaison committee (the local equivalent of the family and birth forum) to design services that met the needs of women and their families.

Access and flow

- Women with high-risk pregnancies could still receive their outpatient antenatal care at the Friarage with a consultant obstetrician but needed to deliver their babies in a consultant-led obstetric unit where facilities for complications were more immediately available. These women were transferred to the James Cook University Hospital.
- Since October 2014 there had been no closures in the midwifery led unit.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as required. Midwives were available on call 24 hours a day for advice. Community midwives were integrated within the service.
- The maternity day unit was opened five days a week from 9am to 5pm. There was always a consultant and registrar available in the clinic.
- There was no evidence to suggest that capacity in clinics interrupted the provision of services in antenatal care. This meant women experienced shorter waiting times. One woman told us she had waited for less than 10 minutes before being seen.
- Communication was sent to the GP, community midwife and health visitor electronically on discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken. The discharge summary was checked first with the woman who signed to say they were happy with the content.

Meeting people's individual needs

- Antenatal women who had concerns about their impending labour and delivery could be referred to the 'Talking about Birth' midwifery-led clinic. The aim of the clinic was to: reduce patient anxiety levels and also to reduce elective caesarean rates (where not clinically indicated); discuss any 'issues' outstanding from a previous birth which were impacting on the current pregnancy; and discuss and formulate birth plans when women were expressing a choice which fell outside the criteria for their individual risk (National Service Framework, Standard 11, 2004).
- Women were referred to services which the midwife and woman felt were appropriate; these included, talking therapies, aromatherapy, natal-hypnotherapy, consultant clinic, counselling via the GP, reflexology and parentcraft.
- A newborn hearing screener was available on the postnatal ward two sessions per week. Midwives were trained in carry out newborn physical examinations and

paediatric staff routinely attended to review babies prior to discharge. The ward ensured that two suitably trained midwives were on duty at weekends to avoid any delays in discharge. The trust was achieving the national standard of examinations within 72 hours.

- Postnatal women had the opportunity to discuss any outstanding issues with their community midwife on the first postnatal community visit. Women were given a contact number to call if they had any outstanding issues which could not be resolved by the community midwife. The clinical matron was dealing with these enquiries via the telephone or, if required, at a meeting. As a result of this process, three women and their partners attended for a debrief meeting with the clinical matron and a consultant obstetrician. One of the patient experience stories was recorded and shared with teams for learning.
- All women with a body mass index (BMI) of 30 or more were placed on a special care pathway. The service worked in partnership with local authority commissioners to provide services for those with a BMI of 30 to 39.9 in community weight management programmes. Specialist midwifery-led services were available for these women to attend, such as a healthy lifestyle clinic for women with a BMI greater than 40.
- Staff could access interpreter services and were piloting the use of a system which enabled two-way telephone conversations to be translated into the required language.

Learning from complaints and concerns

- Complaints and concerns were included on the performance dashboard and regularly monitored at governance meetings.
- When complaints were received, staff offered to meet the complainant, and any meeting was followed up in writing, detailing the outcome.
- The service produced an annual complaints report which went to the Trust Board. The report for 2013/14 showed the main themes for complaints in obstetrics related to communication, staff attitude and labour debrief. A number of actions had been taken to address these areas, including discussions with all postnatal women regarding issues of concern, the introduction of weekly patient experience rounds and changes to practice guidelines.

Are maternity and gynaecology services well-led?

Outstanding ☆

Leadership in maternity and gynaecology services was outstanding. The service was managed by a strong, cohesive leadership team who understood the challenges of providing good quality care and had identified effective strategies and actions needed to address these. This was particularly evident with the reconfiguration of services which were well-developed and understood throughout the department.

Staff were encouraged and able to input ideas and were empowered to develop and implement solutions to provide a high-quality service.

Governance arrangements were embedded at all levels of the maternity service and enabled the effective identification and monitoring of risks, and the review of progress on action plans. Regular detailed reporting at departmental and board level enabled senior managers to be aware of performance and where improvements had had a positive impact on service delivery.

An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The views of the public and stakeholders were actively sought through participative engagement, recognising the value and contributions they brought to the service. Staff were encouraged to drive service improvement and used creative and innovative ways to ensure they met the needs of women who used the service.

Vision and strategy for this service

- The service could demonstrate a clear short- and long-term strategy for maternity and gynaecology services. The strategy included a programme to ensure services and patient activities were physically organised in a way to optimise operational efficiency and patient experience. A reconfiguration of maternity services was completed in October 2014 providing a midwifery-led unit at the Friarage Hospital, with consultant-led care being transferred to James Cook University Hospital.

- Frontline staff felt they had been fully consulted about the changes and saw this as a positive opportunity to shape future service provision and improve patient care. The leadership team told us staff had been "brilliant in adapting to new roles and ward areas".

Governance, risk management and quality measurement

- There was a well-defined governance and risk management structure. The maternity risk management strategy set out clear guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure that poor-quality care was reported and improved.
- Comprehensive quarterly and annual risk management reports were produced. The service used a tracking and trending system which detailed the key themes and trends from incidents, complaints and claims.
- The service demonstrated a dedicated focus on understanding and addressing the risks to patient care. Two dedicated, full-time risk management midwives and a clinical governance lead held regular clinical incident panel meetings and reviewed all adverse outcome incidents. The midwives worked proactively with wards, audit leads and supervisors of midwives and contributed to governance processes to recognise and raise concerns and ensure safe practice.
- Staff at all levels were required to attend at least one risk and audit meeting per year and senior midwives (band 7) had to attend at least two meetings per year. Attendance was monitored and reviewed as part of the staff appraisal process.
- Change action reports were completed, identifying recommendations for improvements and including regular review of pathways and proformas. Key individuals were identified to perform live audits within clinical areas and report back on compliance to individuals and teams. Lessons learned were circulated to all managers and clinical directors to allow them to brief teams, display on information boards and discuss at staff supervisions or appraisals.
- Performance and outcome data was reported and monitored through the service performance dashboard. Any outliers (services lying outside the expected range of performance) were reviewed and timely action taken. We looked at the actions taken following two incidents relating to ambulance delays for the transfer of women. Reports showed that each incident had been thoroughly investigated and had resulted in no harm to the women or babies. The head of midwifery told us that commissioners of service had purchased an additional ambulance to reduce delays in transfer.
- Local risk registers were in place which assisted the corporate governance group to identify and understand the risks. We reviewed information which indicated the description of the risk and subsequent action taken, plus the outcome, where known. We found there was clear alignment of what staff had on their 'worry list' with what was on the risk register.
- The Trust Board had a responsibility to review performance against the quality indicators on a monthly basis. Monitoring was carried out through the quality performance dashboard and the board received progress updates against any improvement projects. Regular meetings and ongoing communication was evident across the two hospital sites. The head of midwifery and matron worked at the Friarage one day a week and met with managers on a regular basis.
- Governance documents clearly identified the roles of the supervisors of midwives and the local supervising authority. Supervisors of midwives told us they attended in this capacity and not in a dual role. This was in line with recommendations by the Nursing and Midwifery Council.
- Most staff we spoke with had an awareness of the new Duty of Candor regulations (introduced in November 2014) and said that information had been sent in the staff bulletin. Policies of openness were already in use and an open culture was observed for reporting and responding to incidents and complaints. The service was in the process of carrying out a gap analysis and action plan to deliver the Duty of Candour requirements.

Leadership of service

- Leadership was encouraged at all levels within maternity services. Ward managers had completed the NHS leadership programme and staff were able to input ideas and were empowered to develop and implement solutions to provide a high-quality service.
- We observed a strong, cohesive leadership team who understood the challenges for providing good quality care and had identified strategies and actions needed to address these. This was evident in the management of the reconfiguration of services. Action plans showed close collaborative working with commissioners and

rigorous assessments of the impact of any changes, including overall risk, travel, ambulance services, and impact on neighbouring trusts, the local economy and equality.

Culture within the service

- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff were able to report when errors or omissions of care had occurred, and use these to learn and improve practice. For example, patient stories and postnatal debriefs were used for learning at study days.
- We observed strong team working, with midwives working cooperatively and with respect for each other's roles. All staff spoke positively and were proud of the quality of care they delivered.
- Staff told us about the 'open door' policy at department and board level. This meant staff could raise a concern or make comments directly with senior management which demonstrated an open culture within the organisation.
- Staff experience 'walkabouts' were being piloted in maternity services. These were used to deal with any issues at an early stage and generate conversations in clinical areas with managers and staff. Themes and actions were collated and presented with the quarterly patient experience summary.
- Staff absence due to sickness was 1.3% against a national target of 4.06%.

Public and staff engagement

- There was evidence that the trust had engaged extensively with patients, public and staff over the reconfiguration of local services. Information was widely shared about the changes to maternity care, including a mail drop to all homes and businesses in the Hambleton and Richmondshire area and the wider area covered by the Friarage Hospital.
- The service actively promoted patient experience projects which included weekly patient experience walkabouts and the 15 Steps Challenge (NHS Institute for Innovation and Improvement in 2013). The 15 Steps Challenge is a series of toolkits which are part of the productive care workstream. The toolkits help look at care in a variety of settings through the eyes of patients and service users, to help capture what good quality care looks, sounds and feels like. The 15 Steps Challenge was carried out in different maternity clinical areas each month.
- The service actively sought the views of women and their families. A questionnaire was given to all women who were transferred to James Cook University Hospital. Action had been taken in response to feedback – for example, the provision of duvets to keep women warm during transfer.
- The families and birth forum was a functional, multidisciplinary group where comments and experiences from women were used to improve standards of maternity care. The head of midwifery told us they were actively seeking to improve representation and promotion of the forum within the clinical areas, the trust's website, posters and at local events.

Innovation, improvement and sustainability

- All staff spoke passionately about the services they offered and the creative ways they worked to ensure they met the needs of women who used the services. They explained how their systems and processes were always developing in line with latest research and guidance. The service was working hard to promote the 'normal birth' agenda and developing clinics and services to encourage women to use the midwifery-led unit. For example, 'early bird' sessions run from clinics to provide women with information prior to formal booking.
- There were effective processes to ensure efficiency and sustainability of services was achieved without impacting on the quality of patient care. The service had achieved its cost improvement targets year on year.
- Multidisciplinary working parties of the most appropriate staff were set up to develop, discuss and test new ideas and guidance. Changes to services were implemented in a controlled way and audited appropriately. This was particularly evident during the reconfiguration of services across sites.

Services for children and young people

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The directorate of paediatrics and neonatology was responsible for services for babies, children and young people at the Friarage Hospital. The children's service at Friarage was monitored and managed by the children's management team located at James Cook University Hospital. Services at Friarage Hospital included a dedicated short stay paediatric assessment unit (SSPAU) open between 10am and 10pm seven days per week and a children's outpatient department. The SSPAU provided short stay assessment and treatment for children under the paediatric medicine specialty. Some short stay minor surgery was also performed every week at the unit including the specialties of plastic surgery, general surgery, oral surgery and community dental surgery.

The current service was provided following reconfiguration of children's services and came into effect on 1 October 2014. The Friarage Hospital previously had a children's ward open 24 hours per day, a children's outpatient department and a special care baby unit (SCBU). The SCBU closed as part of the reconfiguration and an additional 10 cots were opened at the neonatal unit at James Cook. The main children's services were located at James Cook University Hospital in Middlesbrough and included a range of specialties and inpatient areas.

Based on statistics provided by the trust, it served a population of 62,389 children in the NHS South Tees area and 30,468 children in the NHS Hambleton, Richmondshire and Whitby area.

During our inspection, we visited the SSPAU and the children's outpatient department. There was only one young person attending the SSPAU during our visit and the outpatients department was not open, which limited who we could talk with. We spoke to two medical staff and four nursing and allied healthcare professionals, and examined eight medical/nursing records. We spoke with one young person and reviewed 63 parent questionnaires submitted since 1 November 2014.

Services for children and young people

Summary of findings

The children's services actively monitored safety, risk and cleanliness. We did not identify any concerns regarding nursing and medical staffing at the Friarage Hospital.

At Friarage Hospital there was only one young person available to talk with during our inspection visit and they were very happy with the care they received. We reviewed 63 questionnaires submitted since 1 November 2014 and these showed parents provided positive feedback with no negative responses.

We found that a recent service reconfiguration was being closely monitored and managed in partnership with commissioners and other healthcare providers. We found that access and flow was good in the Friarage Hospital and its link to the main children's services at James Cook University Hospital.

The service had a clear vision and strategy based on the National Service Framework for Children. The service was led by a positive management team who worked well together. The service regularly introduced innovative improvements with the aim of constantly enhancing the delivery of care for children and families.

Are services for children and young people safe?

Good

Evidence demonstrated staff awareness of how to report incidents using the trust's reporting mechanisms and we saw that these were reviewed and acted on by the management team. We found that risks were regularly assessed and monitored, and control measures put in place. We found that all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected.

Members of staff of all grades confirmed that they received a range of mandatory training, although training records did not always accurately reflect training take-up. Levels of nursing staff and medical staff were sufficient to meet the needs of children and young people.

Incidents

- Staff demonstrated an awareness of how to report incidents using the trust's reporting mechanisms. The management team and ward managers in all clinical areas felt their staff were good at reporting incidents. We were told by staff that they were able to receive feedback about incidents they had reported.
- The directorate routinely collated quarterly risk management reports which set out a summary of quarterly incident totals, the top 10 incidents during the period, followed by a summary of action taken where appropriate. For example, the paediatric quarter two report (from when the SSPAU was a children's ward and the SCBU was open) had no significant top 10 incidents.
- We reviewed incident data for Friarage Hospital paediatric services submitted via quarterly risk management reports. For April 2013 to March 2014, a total of 94 incidents had been reported with none classified as moderate to severe.
- As part of the reconfiguration of the children's service, staff on the SSPAU were required to submit incident forms for monitoring purposes to check the impact of the new service. The ward manager explained that 40 incidents had been submitted since 1 October 2014, of which 32 were transfers of children to the James Cook

University Hospital. We were told that only one of these incidents was classified as a 'moderate' concern and was regarding a transfer which had resulted in a "protracted delay" in the ambulance transfer. This incident was being reviewed at the time of our inspection to identify any actions that may be required.
- There was a nominated clinical lead for risks and incidents who was a consultant paediatrician. The paediatrician sent out a weekly email which we were told contained a "short and snappy" message regarding a lesson of the week which had been identified from incidents, risks or complaints at the Friarage hospital. The aim of the email was to promptly share learning with all members of staff.

Cleanliness, infection control and hygiene

- We found that the SSPAU and children's outpatient area were kept very clean and tidy. Various infection-prevention measures were in place, such as multiple wall-mounted hand gel dispensers and hand-wash sinks.
- We observed that all clinical areas, members of medical, nursing and other staff regularly performed hand hygiene measures.
- The matron explained that regular cleanliness checks were undertaken. In addition, weekly compliance checks were completed by the ward manager. We were told the children's directorate felt well-supported by the trust-wide infection prevention and control team.
- We saw that meeting minutes included regular feedback regarding infection control and prevention.

Environment and equipment

- We saw, and staff told us, that all clinical areas had a wide range of clinical and other equipment to assist them in providing care for children and young people. Records showed that the trust regularly tested and serviced equipment.
- The areas we visited had suitable resuscitation equipment available, which had been checked regularly by members of staff.
- We found the SSPAU and the outpatient unit to be spacious, well-lit and uncluttered. The SSPAU had a range of facilities available to assist staff in providing care. For example, one cubicle had a roof-mounted hoist which travelled between the bed space area and the en-suite shower room.
- There was a dedicated children's outpatient department which had a spacious waiting area.

Medicines

- We reviewed a sample of paper-based treatment records and observed the administration of an intravenous medication to a young person attending the SSPAU. We found that medicines had been appropriately stored and checked.

Records

- We found that records were managed and handled safely during our inspection. For example, we did not identify any unattended medical notes during our inspection.
- We reviewed eight medical notes of children recently admitted to the SSPAU. We found that the respective paediatricians and surgeons had appropriately completed paper-based medical records.
- Nursing and medical staff completed a joint multidisciplinary documentation record on admission which recorded a range of jointly assessed information such as social history, medications, observations, allergies, nursing assessment and clinical notes. This meant that the joint assessment entries were written at the same time, alongside each other, so that it was clear what treatment and care the child required.

Safeguarding

- Managers and members of staff within children's services demonstrated a clear awareness of the referral processes they must follow if a safeguarding concern arose.
- The head of nursing told us that clinical staff who worked with children should be trained to the level 3 safeguarding children standard. The full level 3 training was delivered once for each staff member, followed by level 3 update training annually, delivered on a rolling programme.
- Ward managers kept their own training records and they told us the trust system did not accurately reflect training completed. Local training records showed that eight out of nine staff had completed level 3 safeguarding training.
- The trust had the necessary statutory staff in post for safeguarding children, including the named nurse and named doctor. The director of nursing was the nominated executive lead for safeguarding.

- The matron explained that the directorate was well supported by the trust-wide safeguarding team.

Mandatory training

- The ward manager explained that overall compliance with mandatory training stood at around 78%. Local staff training records showed that some subject areas, such as fire safety and health and safety training, was at 100% take-up (nine out of nine staff members). Other training subject areas showed that some staff needed to complete training, for example – for conflict resolution, five out of nine staff had yet to complete this training.

Assessing and responding to patient risk

- We reviewed eight care records which showed individualised clinical risk assessments were completed on admission and reviewed regularly. These risk assessments included areas such as a children's pressure sore risk tool and a nutritional screening tool. A broader safety checklist was also completed and maintained which covered a range of individual safety checks.
- The children's clinical areas used an early warning assessment/clinical observation tool based on a standard type Paediatric Early Warning Score (PEWS) tool. The tool included a clinical observation chart along with an assessment table to assist clinical staff in determining the action that should be taken.

Nursing staffing

- The head of nursing and clinical matron explained that recruitment and retention were good within the children's clinical areas across both hospitals, so vacancy rates were low. Children's services directorate meeting minutes included a section titled "organisational capability" which discussed staffing matters.
- The ward manager explained that there were two registered children's nurses on duty as a minimum to staff the SSPAU's opening hours, in addition to the ward manager being available for certain periods of time. This was to staff 10 beds/cots, including one four-bed bay, four cubicles along with an acute assessment area which had space for two beds.
- The children's outpatient department operated as an extension of the main children's outpatient department at James Cook. Two staff members were permanently employed at the Friarage children's outpatient department, including a part-time receptionist and a healthcare assistant who worked 32 hours per week. The children's outpatient department ward manager from James Cook was responsible for the Friarage department. They explained that there were around six to eight sessions per week and some, but not all, of these outpatient sessions were covered by a registered nurse, normally based at the James Cook site.

Medical staffing

- Medical staffing of the SSPAU was consultant-led on-site 12 hours per day, seven days per week. Paediatricians who covered the Friarage Hospital paediatric medicine rota were based both at the hospital and at the James Cook site. The consultant was supported by trainee doctors during weekdays.
- During our visit to the Friarage Hospital, we talked with one duty consultant paediatrician (the clinical director) and the duty trainee doctor. The trainee doctor explained that it was often very quiet on the SSPAU which affected the level of experience gained. The clinical director was concerned that weekends may not always be an effective use of a consultant paediatrician's time due to low admission numbers. For example, on Saturday 29 November only two children were assessed within a 12-hour period and on Sunday 30 November only four children.

Are services for children and young people effective?

Good

The trust had systems and processes to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based, best practice guidance. We reviewed information that demonstrated that children's services participated in national audits that monitored patient outcomes when these were applicable. Medical staff had a proactive programme of clinical audit which looked at outcomes for children and young people.

Children and young people had access to a range of pain relief if needed and an evidence-based pain-scoring tool was used to assess the impact of pain. The nutritional needs of children were addressed. Consent forms were

completed to an adequate standard and staff showed awareness of Gillick competencies guidelines for deciding whether a child is mature enough to make decisions and give consent.

Staff had received an annual appraisal and received support and personal development. Members of staff gave positive feedback about the individual support they received regarding their personal development. There was clear evidence of positive multidisciplinary working across various disciplines and specialties.

Evidence-based care and treatment

- The trust had systems and processes to review and implement (NICE guidance and other evidenced-based, best practice guidance. The clinical director acted as the service lead for the review of guidance and supported its incorporation into protocols where required.
- Discussion with clinical staff and the review of a number of submitted documents demonstrated that the service participated in national audit such as diabetes, epilepsy and asthma. Evidence was submitted, including action plans, which showed that the service had reviewed the audit results of these national surveys and set actions to identify improvement. For example, the asthma audit action plan included actions such as improving the recording of information and the development of a study to investigate higher readmission rates.
- The trust also produced quarterly clinical audit activity reports for paediatrics. This document contained a large number of audits, either with a status update for audit in progress or a detailed summary of findings for completed audit. The various documents demonstrated the service's pro-active approach toward audit activity which was largely focused on clinical outcomes for the child.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics.
- The service used evidence-based pain scoring tools to assess the impact of pain. We reviewed a sample of pain score ratings, which showed that members of staff regularly assessed pain when required.

Nutrition and hydration

- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment of the child's daily activities. The nursing team used a nutritional assessment tool for children known as the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP). We reviewed a sample of nursing records which showed that these records had been appropriately completed.
- Children were able to choose their food from the daily menu with the support of parents and staff. Children could eat food from the adult menu or have a meal from the children's menu. The SSPAU had a menu board available on the ward which displayed the menu. Snacks and drinks were available inbetween meals.

Patient outcomes

- We reviewed information that demonstrated that children's services participated in national audits that monitored patient outcomes when this was applicable to the service.
- An alternative system had been set up to gain the views of children, young people and families about their experiences within the children's service. The SSPAU asked parents and children to complete a questionnaire during their stay. The questionnaire asked questions such as how welcome they'd felt, were they seen in a timely manner by the doctor and nurse, and had they been kept informed and updated. We reviewed a sample of 63 questionnaires completed since 1 November 2014 and found all responses from parents were very positive and included a number of favourable comments.

Competent staff

- Formal processes were in place to ensure that staff had received training and an annual appraisal.
- We did not review any documents which recorded appraisal statistics but the ward manager for the SSPAU confirmed that eight out of the nine staff employed on the unit had had an appraisal. Members of staff we talked with confirmed they had received an appraisal.
- Trainee medical staff we spoke with at both hospitals were positive about the regular training and support they received to develop their clinical and educational knowledge and skills. They felt well-supported by consultant staff within paediatrics.

Multidisciplinary working

- Medical and nursing staff within the children's services at Friarage hospital gave positive examples of multidisciplinary working. We were told that the paediatricians and nursing teams worked closely together and also with other allied healthcare professionals such as dieticians, occupational therapists and physiotherapists.

Seven-day services

- The children's inpatient services accessed diagnostic services such as the x-ray department, pharmacy and laboratory during the weekend. Staff did not raise significant concerns over accessing these services.
- The SSPAU was consultant-led and reviewed all children attending the unit during the weekend. We were told the consultants worked closely with, and offered support to, the emergency department at Friarage Hospital where children with minor injuries could still attend following the reconfiguration.

Access to information

- Staff told us they were readily able to access patient information and reports, including at weekends and out of hours. Trainee medical staff were given their computer log-in passwords straight away which allowed them access to the system on their first day working at the trust.

Consent

- Minor surgery was offered via some elective weekly sessions held at the Friarage Hospital.
- We reviewed a sample of eight records of recently admitted children on the SSPAU, including some where consent had been obtained for surgery, and found that these had been appropriately completed, dated and signed by the doctor or surgeon and parent.
- The ward manager and other SSPAU staff showed that they understood the Gillick competency standard for deciding whether a child is mature enough to make decisions and give consent. Staff explained that the consent process completed by surgeons actively encouraged young people to be involved in decisions about their proposed treatment.

Are services for children and young people caring?

Good

Children, young people and parents told us they received compassionate care with good emotional support. They felt they were informed and involved in decisions relating to treatment and care. We spoke with one young person and reviewed 63 questionnaires from families admitted since 1 November 2014 which gave examples of how parents and children had been provided with supportive care centred on their personal needs.

Compassionate care

- Throughout our inspection across both hospitals, we observed members of medical and nursing staff who provided compassionate and sensitive care that met the needs of children, young people and parents.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with children and parents.
- The environment was pleasant and welcoming on the SSPAU and children's outpatient department, both of which promoted family-centred care.
- We spoke with one young person during our visit to Friarage Hospital who attended the SSPAU regularly for treatment. They felt the staff were dedicated and happy staff who were like "family" and felt comfortable and confident in speaking with them. The young person felt the new unit had less "bustle" and was quieter since the reconfiguration.
- We were told that children's services did not participate in the NHS Friends and Family Test. The SSPAU asked all families who attended to complete a locally developed questionnaire.
- We reviewed all 63 questionnaires completed since 1 November 2014 and found all responses from parents were positive. As the unit was very quiet during our inspection, we recorded a number of comments made by parents and children in the questionnaires. Parents said, "We felt everyone that dealt with [my child] today was friendly and supportive. We were well looked after", "[The nurse] was brilliant. She talked to us in a friendly, professional manner. All the theatre staff were excellent too," and a child stated, "The staff were nice and friendly".

Services for children and young people

Understanding and involvement of patients and those close to them

- We observed that members of staff spoke to young people using age-appropriate language.
- Parents responded to the local questionnaire with positive comments about their understanding and involvement in care. For example, one parent stated that it was a "fantastic service, quick, friendly and very understanding".
- Questionnaire responses were positive about the information parents had received and how they had been given sufficient information to make an informed choice about their children's care.
- Information leaflets about various treatments and other care were available within the hospital. Leaflets at this trust were written in English. Members of staff explained that they could get leaflets translated when required.

Emotional support

- Parents also made it clear through the questionnaires that they could talk to a member of staff when they felt concerned or anxious during their children's stay in hospital. Parents' comments were positive about the care and emotional support they had received within the children's clinical areas. For example, parents said, "Everyone was lovely and friendly and made my son feel at ease through his experience. Information given was clear and understandable", "The nurses, doctor and consultant all kept us up to date with their thoughts on what was going to happen" and "Fantastic …helped put my mind at rest that my child was okay".

Are services for children and young people responsive?

Good

The children's service actively planned and delivered services to meet the needs of local families. We found that the recent service reconfiguration was being closely monitored and managed in partnership with commissioners and other healthcare providers.

Access and flow was good within the children's service at Friarage Hospital.

Service planning and delivery to meet the needs of local people

- A range of evidence was available that demonstrated how the children's service engaged with the trust, commissioners, the local authority and other providers to address the needs of the local population.
- A commissioner-led service reconfiguration had recently been undertaken in relation to the Friarage Hospital children's services. This had led to the closure of overnight inpatient beds for children and the children's ward had become an SSPAU, open from 10am to 10pm seven days per week. The SCBU had also closed at the Friarage Hospital and 10 additional cots had opened at James Cook's neonatal unit to replace these cots. The children's outpatients department remained open at the Friarage Hospital. These changes had occurred from 1 October 2014.
- We saw that the trust and other partners had proactively planned these changes and undertaken a range of work to ensure the local population were aware of what to do now the 24-hour inpatient ward had closed. Various information posters and leaflets had been produced to inform people of the changes and what they should do when their child became poorly.
- We found that the trust was closely monitoring the reconfiguration of services in relation to the impact at the Friarage Hospital and the impact on services at the James Cook University Hospital. Currently every transfer from Friarage Hospital was being reviewed (and reported as an incident to facilitate close monitoring) and we were told that an audit had just been completed immediately prior to our inspection. Statistics so far showed the number of transfers to James Cook hospital had been low, at 32 transfers since 1 October up to the time of the inspection. Of these, few occurred after 6pm, for example, in the week 17 to 23 November, three children were transferred after 6pm and none on five of the seven days.
- The head of nursing and the matron explained that there was a weekly telephone conference call between the clinical commissioning groups, emergency departments, ambulance service, children's services and maternity services to discuss the reconfigured services.

Access and flow

- The service reconfiguration had meant the access and flow to children's services at this hospital had changed. The emergency department still accepted children, although this was for minor injuries, minor burns and other minor illness. The local general practices and emergency ambulance providers were aware that poorly children should be transferred directly to James Cook. Leaflets and other publicity had been produced to advise parents living locally on what services they should access and where.
- The SSPAU provided assessment, monitoring and treatment for children referred by their GPs or who had an open access arrangement. Where a child may require a longer stay or overnight care, formalised protocols and arrangements were in place to transfer the child to the wide-ranging children's inpatient services available at James Cook.
- We reviewed the number of admissions and transfers for a two-week period from 17 to 30 November 2014. This showed that the service was quiet on most days and the number of children transferred daily to James Cook was relatively few. Transfers after 6pm had only occurred on some days. In the week commencing 17 November 2014, three children were transferred, while in week commencing 24 November 2014, eight children were transferred.

Meeting people's individual needs

- Staff told us that interpreting services were available when they needed them, and that they did not normally have any issues when accessing these services.
- The children's ward areas had facilities to promote family-centred care. For example, parents had access to a seated area and facilities to make hot drinks.
- The SSPAU had various facilities to meet the needs of children and young people with physical disabilities, such as a dedicated cubicle with roof-mounted hoist between the bed space and shower facilities.
- There was a range of play facilities available for younger and older children, including an outdoor enclosed area. The service did not currently employ a play specialist. Play and distraction needs were attended to by other members of staff such as the nursing team.

Learning from complaints and concerns

- The monthly children's services directorate meetings included an agenda item for complaints under the 'quality of care and patient safety' standing item, and minutes showed that these meetings reviewed and discussed complaints.
- Lessons learned via complaints were shared via a weekly email which set out a lesson of the week which had been identified from incidents, risks or complaints. The aim of the email was to ensure that learning could be promptly shared with all members of staff.

Are services for children and young people well-led?

Good

The service was well-led. Robust governance and risk management arrangements were in place. There was a clear vision and strategy for the service, based on best practice set out in the Department of Health's National Service Framework for Children. The service was led by a strong management team who worked well together. The service regularly implemented innovative improvements with the aim of constantly improving the delivery of care for children and families. Although there was an executive director for safeguarding children, the trust did not have a formally nominated board-level director who championed children's rights.

The service engaged with people who used the service through a range of methods. The service involved children and families in decisions regarding the service and facilitated a range of support groups. We found outstanding areas of innovative practice regarding the care and involvement of young people at James Cook University Hospital.

We found a positive, open and friendly culture at the service. Staff placed the child and the family at the centre of care delivery, and this was seen as a priority and everyone's responsibility.

Vision and strategy for this service

- The trust had a children's specific strategy entitled the Children and Young People Strategy which was valid for the period 2012 to 2017. The strategy included an overall vision with five linked strategic vision statements. The overall vision stated: "To deliver services that meet

the health needs of children, young people, parents and carers and provide effective and safe care, through appropriately trained and skilled staff working in a suitable child friendly and safe environment".

- The strategy set out core values and strategic themes regarding quality of care and patient safety, business sustainability, organisational capability and partnerships and engagement. Strategic objectives were outlined for core children's services, such as neonatal services, surgery, medicine, outpatients, inpatients, ambulatory care, child therapy services and community services.
- Part two of the strategy used the standards set out in the Department of Health's National Service Framework for Children, Young People and Maternity Services. The strategy, in tabular form, mapped the strategic objectives identified for each core children's service against a target (National Service Framework standard) and the strategic vision.

Governance, risk management and quality measurement

- The children's services risk register included four listed risks. None of these risks related to the children's services at the Friarage Hospital.
- Risks were regularly discussed in children's service directorate meetings. In addition, quarterly risk management reports were produced. The women and children's centre produced quarterly patient safety governance reports which included current risks. Risk meetings were held separately for paediatrics at James Cook and Friarage hospitals, neonatology and community children's services. The children's management team explained that, as many of the risks and incidents were similar, the four risk meetings would be merged into one monthly meeting.
- The leadership and clinical teams held a range of meetings which covered clinical governance matters regarding the children's service. There was a monthly children's service directorate meeting which included agenda items centred around the children's strategy's themes. These meetings included members of the children's leadership team at ward and unit level along with the children's management team, including the clinical director, head of nursing, matron and directorate manager.
- The clinical director for paediatrics explained that the directorate clinical audit and governance meetings discussed a range of matters, including child death review processes, actions from incidents and complaints, and other matters such as the presentation of clinical audit. This was a consultant-led meeting but open to the multidisciplinary team to attend. This particular meeting did not currently record formal minutes.
- The children's nursing leadership team also held regular meetings. These meetings included attendance by the head of nursing, matron and band 7 ward managers. Meeting minutes showed that more detailed discussions were held about a range of areas such as infection control, training and other matters.
- The children's management team formed part of the monthly women and children's centre meetings. This meeting was more corporate and business-focused and discussed matters such as finance. We reviewed a sample of meeting minutes which showed that the meeting also discussed quality issues. Recent minutes had included updates relating to the reconfiguration of Friarage Hospital services.
- The head of nursing, the matron and directorate manager showed a clear awareness of the new Duty of Candour regulations that came in to effect in November 2014. Other staff we talked with showed some awareness, though a small number did not know what the duty meant.

Leadership of service

- The directorate of paediatrics and neonatology formed part of the women and children's centre. There was a centre chart which set out a multi-tiered structure within the directorate and centre.
- Within the directorate of paediatrics and neonatology there was a separate clinical director for paediatrics and neonatology. There was a directorate manager for paediatrics. Nursing leadership within the directorate included a head of nursing who was supported by a clinical matron. Each clinical area was led by a band 7 ward manager who was supported by band 6 sisters. The directorate had shared access to supporting services such as governance.
- The children's management team (clinical directors, head of nursing, directorate manager and matron) reported to the centre management team which included a managing director and a senior clinician who was appointed as the chief of service.

- We spoke with the band 7 ward manager of the SSPAU who said they felt well-supported by the head of nursing and the matron. The ward manager explained how well-supported they had felt by the leadership team during the recent configuration of the service. The ward manager of the SSPAU displayed an in-depth knowledge and commitment to their unit and clearly wanted to ensure the newly reconfigured service would successfully serve the local population's needs.
- We found that children did not have adequate representation at the Trust's Board level, which was a view shared by some of the clinicians we talked with. There was an executive board lead for safeguarding children (the director of nursing). We could not identify that there was a formal board-level director to promote children's rights and views as recommended by the National Service Framework for Children's standard for hospital services.

Culture within the service

- We found a culture of openness and flexibility among all medical, nursing and allied healthcare professional staff we met in the children's service. Staff spoke positively about the care they provided for children, young people and parents.
- We saw that staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children.
- The leadership team demonstrated how they took pride in their service and enthusiastically provided a number of examples of how the children's service had developed.

Public and staff engagement

- We found that people's experiences of the service were regularly sought. On the SSPAU, parents and children were asked to complete a questionnaire during their stay and the ward manager explained how these were reviewed and acted on where needed.
- Staff we spoke with told us they had been engaged prior to and following the recent reconfiguration of services at the Friarage Hospital. We also heard individual examples of how members of staff had been engaged and supported by each other and members of the leadership teams at ward and directorate level. The management team explained they were developing a 'thank and praise' ethos to develop positive approaches and support for members of staff.

Innovation, improvement and sustainability

- The children's service, its consultant paediatricians and other staff had introduced innovative ideas to improve service provision and sustainability for children and families who used the service.
- A review of practice regarding medication administration led to the development of a systematic approach from policy known as the '10 steps to safer medication'. This process set out a clear process for staff to follow from prescription through to administration of medicines. Documentation showed the new process led to a 46% reduction in medication incident reports for April 2010 to March 2011. Staff had received ongoing DVD and workshop training and risk meeting minutes showed continued review of medications incidents and practice. This was good practice which demonstrated how medications management had been improved and sustained following formalised changes to practice.
- The children's service demonstrated how it reviewed the latest evidence-based tools and took action to introduce them. For example, the children's service had previously used the Braden Q scale for predicting paediatric pressure ulcer risk (adapted from the adult's pressure sore risk calculator). A review of pressure incidents from the period April 2011 to April 2014 showed there had been 14 grade 2 pressure ulcers and four grade 3 ulcers. Of these, 61% had occurred in children with disabilities with 55% of ulcers being directly caused by pressure from equipment. The team conducted a literature review and identified a more recently developed tool known as the Glamorgan risk assessment scale which was found to be more accurate at identifying children with mobility issues at risk of pressure sores. The new scale had been recently introduced.

End of life care

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good
Overall	Requires improvement

Information about the service

The Friarage Hospital formed part of South Tees Hospitals NHS Foundation Trust and provided end of life care services on-site and in partnership with the James Cook University Hospital, community and hospice services. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team (SPCT). The SPCT comprised one full-time palliative care consultant and one half-time respiratory care consultant with an interest in palliative care across both sites. There was an end of life lead nurse who was based at James Cook and a community in-reach clinical nurse specialist (staff from all wards who work with A&E departments to facilitate patient moves to wards and discharge) with responsibility for the Friarage. All patients requiring end of life care could have access to the SPCT. We saw that hospital referrals to the service for 2013/14 totalled 95, an increase of almost 20% from the previous year.

During our inspection we spoke with members of the SPCT, the non-executive director lead for end of life care, members of the end of life steering group, bereavement support staff, mortuary staff, the chaplain, ward managers, nursing staff and allied healthcare professionals. In total we spoke with 14 staff. We visited a number of wards across the hospital, including the clinical decisions unit, Ainderby ward, Romanby ward, Allerton ward and the A&E department. We also visited the mortuary. We reviewed the records of three patients at the end of life and reviewed 12 do not attempt cardio-pulmonary resuscitation (DNA CPR) orders. We spoke with two patients and two relatives and we reviewed audits, surveys and feedback reports specific to end of life care.

End of life care

Summary of findings

End of life services were caring, responsive and well-led but required improvement in order to be safe and effective. DNA CPR forms were not always completed in line with national guidance and trust policy. Patients who were identified as lacking mental capacity did not always have their mental capacity assessments documented.

Training and education for ward-based staff had been problematic due to issues releasing staff from the wards to attend. The specialist palliative care team had approached this issue by delivering more informal ward-based training, however, this hadn't been recorded and so was difficult to evaluate in terms of effectiveness. We saw that education was one of the key themes identified as part of the end of life steering group work programme.

The trust had a care pathway in place which was being used during the transition from the phase out of the Liverpool Care Pathway and the introduction of a new regional pathway. The last days of life care pathway did not include specific prompts around nutrition and hydration assessments and these were sometimes missing in the pathways we reviewed, however, this had been addressed to ensure specific prompts were incorporated into the new guidance.

The SPCT supported ward-based staff with end of life care and they were committed to the development of end of life care skills to improve care for patients. We saw evidence of plans to address issues identified in both internal and external audits and we noted service planning were in progress, centred around seven key themes identified by the end of life steering group.

We saw evidence of innovation with the use of a referral algorithm, palliative care link meetings for ward staff and the use of a fast-track information pack for rapid discharge. The focus of these innovations was to improve support and care to patients at the end of life. Patients and their relatives told us that staff were caring and compassionate and we saw that the service was responsive to patients' needs. There were prompt referral responses from the SPCT and rapid discharge for patients at the end of life wishing to be cared for at home.

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End of life care

Are end of life care services safe?

Requires Improvement

We rated end of life care services as 'requiring improvement' in terms of safe care. Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were inconsistently completed. Of the 12 we viewed, four did not include details of discussions with patients and family members. All 12 forms we viewed had been signed by a consultant, however, five did not have all of the questions answered, and three did not include a date for review. We viewed examples of medical and nursing staff assessing and responding to patient risk within patient records, but some of the records were incomplete. We saw that safety audits were carried out and, in one of the audits we looked at, the use and safety monitoring of syringe drivers had led to syringe driver training being delivered to a number of ward-based nurses.

There were effective procedures to support safe care for patients at the end of life and we saw evidence of learning from incidents. Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients at the end of life.

There was a specialist palliative care multidisciplinary team (SPCMDT) available five days per week, with on-call support and advice available out of hours.

Incidents

- There had been no Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) or serious incidents reported for end of life care in the 12 months prior to our visit.
- Staff told us they knew how to report incidents through the use of Datix patient safety healthcare software.
- Staff were able to give examples of reported incidents and changes in practice that had resulted from the subsequent investigations.
- We were told that one example of an incident reported via Datix related to the number of patients admitted to A&E via nursing homes in the community with DNA CPR decisions in place who died shortly after admission. Staff told us that, when this happened, the nursing home would be contacted by the A&E manager with a view to investigating the appropriateness of the transfer to A&E as opposed to the person being cared for in the home. Staff told us they did not always receive feedback about the outcome of the investigation.

Environment and equipment

- We viewed mortuary protocols and spoke with mortuary staff about the transfer of the deceased.
- The mortuary was staffed during the day until 4pm by a lone mortuary technician in a separate building away from the main hospital. We saw that a number of safety measures were in place, including the use of locked doors and a security alarm.
- The transfer of the deceased during the day was the responsibility of the mortuary technician with support from ward staff, however, during the night it was the role of portering staff. We were told that the deceased were transferred through a corridor at the side of the hospital and we saw this was where the concealment trolley was stored. The trolley had to be wheeled past an open dining area, however, we saw that some effort had been made to minimise the impact of this by not transferring the deceased during meal times.

Medicines

- Palliative and end of life care guidelines for cancer and non-cancer patients had been co-written by the palliative care consultant and had been distributed through the trust's intranet. The guidance included the use of medicines in the management of symptoms including pain, nausea and vomiting, breathlessness and anxiety.
- Patients who required end of life care were prescribed anticipatory medicines (medication that they may need to make them more comfortable).
- There were clear guidelines for medical staff to follow when prescribing anticipatory medicines for patients who needed them. We reviewed medication record charts for patients who were considered to be in the last days of life and, in all cases, we saw that anticipatory medicines were prescribed appropriately and in line with the guidance.
- We did not observe the use of syringe drivers on the wards. However, we viewed an audit of the use of McKinley syringe drivers dated June 2014 to ascertain compliance against the use of a safety checklist against

trust protocol. The results of the audit showed that inappropriate infusion lines had been used and that the four-hourly checks had not been consistently carried out.
- As a result of the audit, the SPCT had re-informed all areas of risk alerts and information had been shared and disseminated through the matron's forum. We saw that this audit was part of an ongoing audit cycle. Nursing staff we spoke with on the wards told us they had attended syringe driver training in the last year.

Records

- Patients identified as being in the last days of life were commenced on the last days of life care pathway. We observed the associated records of three patients who had started care on the pathway. We saw that two of the records had not been completed accurately, with incomplete assessments and records of symptom monitoring and evaluation.
- We viewed an audit of the last days of life care pathway that had been carried out by the SPCT from January to April 2014. This audit highlighted that the assessment of spirituality needs and recording of the preferred place of death were not always consistently completed. Actions to be addressed by the SPCT from this audit included the need to liaise with community colleagues about advanced care planning for patients approaching the end of life.
- We viewed 12 DNA CPR records and saw that these were not consistently completed. Of the 12 we viewed, four did not include details of discussions with patients and family members.
- We did not see evidence of advanced care planning decisions in the medical records of the patients we viewed. All 12 forms we viewed had been signed by a consultant, however, five did not have all of the questions answered, and three did not include a date for review.
- We viewed the notes of a patient who had been admitted to the clinical decisions unit where a DNA CPR decision had been made earlier in the day. The documentation of discussions stated that the patient agreed and wished not to be resuscitated. A few hours later the patient was reviewed by a second consultant and the DNA CPR order was cancelled. The patient's notes stated that they now wanted to be resuscitated. It was unclear from the records of the discussion as to how detailed either of these discussions had been and how informed the patient was.
- We viewed an example of a trust-wide audit (July 2014) of DNA CPR forms that identified issues such as recording of discussions with the patient or relatives and ensuring that the DNA CPR form was correctly completed. We saw that action taken following the audit included the circulation of relevant guidance. We did not see evidence of follow-up audits, although we did see that the annual monitoring of DNA CPR had been added to the trust's audit plan for 2014/15.

Safeguarding

- The SPCT were able to explain what constituted safeguarding concerns and the steps required to report them.
- The trust had mandatory safeguarding training schedules in place as part of staff induction programmes.
- The patients and relatives we spoke with told us they felt safe being cared for within the hospital.
- The SPCT had completed the required adult level 1 and children's level 1 safeguarding training.

Mandatory training

- We were told by the SPCT that, while end of life care training was not mandatory for all staff, training for ward-based staff was considered to be a significant role for the SPCT.
- Ward staff we spoke with reported varying attendance at end of life care training. The end of life lead nurse told us that there had been issues with the ward staff attendance at the end of life care training sessions tailing off, making it difficult for the team to justify running courses on a regular basis. However, we were given examples by some ward staff of training being delivered on the wards by a member of the SPCT, specifically around the use of syringe drivers in end of life care and the use of end of life care revised guidance.
- We viewed an education action plan that included end of life care training being incorporated into a preceptorship practical experience and training programme for all new staff nurses within the trust. We

also saw that the SPCT delivered training for foundation doctors relating to palliative care and communication at the end of life, including discussions around DNA CPR decisions and also hydration and nutrition.
- The SPCT had completing the required mandatory training which included basic life support and manual handling.

Assessing and responding to patient risk

- We observed the use of general risk assessments for patients who had been identified as being in the last days of life. This included the assessment of risk in relation to nutrition and hydration, falls and the potential for pressure area damage.
- Tools used for the management of deteriorating patients included the National Early Warning Score (NEWS) for acutely ill patients, and we observed the tool being used to identify when patients were deteriorating.
- Specific to end of life care, we saw that recognition of the last days of life was generally consistently applied. The end of life lead nurse told us that patients who are recognised as dying could be commenced on the care pathway for the last days of life. We saw examples of the pathway in use and staff told us it was a useful tool in providing a focus for responding to patient risk and need.
- We saw that the current and piloted guidance document for care in the last days of life included a section to document recognition that the patient was ill enough to die. We observed discussions in practice with patients and their relatives around care in the last days of life.

Nursing staffing

- As part of a trust-wide specialist palliative care structure we saw that a whole time equivalent (WTE) community specialist palliative care nurse also provided an in-reach palliative care service to patients at the Friarage Hospital. The specialist nurse providing this service worked as part of a multidisciplinary team that operated across both acute hospital sites (Friarage and James Cook hospitals) and the community.
- Members of the SPCT, including the end of life lead nurse, had time dedicated to spend at the Friarage Hospital
- Nursing staff on the wards told us that they generally felt that the quality of care they were able to give people at the end of life was of a good standard. Some nurses cited staffing difficulties as impacting on general nursing activities, but most felt they were able to prioritise their time based on patient need and deliver care appropriately.
- We were told that a new Macmillan-sponsored pilot was due to start in January 2015 where specialist nurses would be available for on-call advice from 4.30pm to 11pm Monday to Friday and from 8.30am to 4.30pm at weekends. Staff told us that this pilot was being implemented to provide more specialist out-of-hours advice and support given to patients in the community and on the wards.

Medical staffing

- One full-time palliative care consultant was available across the trust with a second respiratory physician with an interest in palliative care working as part of the SPCT based at Friarage Hospital on a half-time basis.
- Out-of-hours specialist medical advice was available through a regional consultant on-call rota that ensured there was a specialist palliative care consultant on call 24 hours a day, seven days a week. This meant that specialist advice was available around the clock.

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Major incident awareness and training

- We viewed business continuity plans for the mortuary incorporating escalation procedures. Business continuity was maintained through contingency planning with the coroner's office, transfer between hospital sites and the use of the trust's contracted funeral director.

Are end of life care services effective?

Requires Improvement

We rated end of life care services as requires improvement for effectiveness The trust had a care pathway in place which was being used during the transition from the phase out of the Liverpool Care Pathway and the introduction of a new regional pathway. We saw that the assessment of nutrition and hydration had been inconsistent for patients at the end of life, with documentation not always being adequately completed in its correct format.

End of life care

We saw that, following the results of the National Care of the Dying Audit, nutrition and hydration had been addressed in the new guidance and plans were in place to develop training in this area.

We saw one record where a patient who was identified by nursing staff as not having mental capacity did not have a documented mental capacity assessment. This was not in line with national guidance or trust policy.

The trust had taken action to plan and develop services in line with national guidance, with action plans incorporating areas of identified development. We saw that members of the SPCT were appropriately qualified to give specialist advice and we saw evidence of good multidisciplinary team working as part of the approach to supporting ward-based staff and patients in delivering good quality end of life care.

Evidence-based care and treatment

- End of life care was based on the National Institute for Health and Care Excellence (NICE) quality standard 13, which sets out what end of life care should look like for adults with life-limiting conditions.
- We viewed an end of life steering group work programme that incorporated guidance from a number of external sources, including NICE, the General Medical Council (GMC) and the National Care of the Dying Audit of Hospitals (NCDAH).
- The trust had local guidelines and policies in place that were up to date and based on NICE guidance. We saw that up-to-date palliative and end of life care guidelines, co-authored by the palliative care consultant, were widely used across the hospital, available in hard copy and via the trust's intranet.
- Initiatives that had been developed by the SPCT included a pilot approach to proactively identify patients who were approaching the end of life earlier to improve their quality of care. As a result, staff told us there were plans to develop this work more widely across the trust, along with more robust outcome measures.
- The trust had a care pathway in place which was being used during the transition from the phase out of the Liverpool Care Pathway and the introduction of a new regional pathway.
- Members of the SPCT told us they had taken the decision to extend the use of their existing pathway (based on the Liverpool Care Pathway) during the pilot phase of the trust's new guidance. The decision had been based on the need for patients to benefit from consistent standards of care during this time. We viewed clear guidance attached to the pathway that incorporated the need for care to be guided by the five priority areas highlighted by the Leadership Alliance for the Care of Dying People.

Pain relief

- The SPCT had developed prescribing guidance to ensure that anticipatory prescribing took place and pain relief was administered to patients in a timely manner.
- Patients at the end of life had their pain assessed, along with other symptoms to promote effective management.
- Pain assessment charts were available on the wards we visited, adapted according to a person's ability to express pain. This included the use of a sliding scale pain score, the assessment of a person's facial expression and the assessment of behaviour and activity.
- We viewed one patient whose pain was assessed regularly using a pain assessment chart and we saw that this had been completed accurately and regularly.
- Patients and relatives told us that pain relief was given as needed. We did not see patients who were in pain during our inspection.

Nutrition and hydration

- A malnutrition universal screening tool (MUST) was used routinely on admission to identify patients who were malnourished or at risk of malnutrition. We saw that these assessments had been completed on the majority of the patients whose records we reviewed.
- Patients' fluid and nutrition needs were assessed and recorded as necessary.
- We viewed results of the 2014 National Care of the Dying Audit and saw that the trust performed below the England average in terms of the review of patients' nutritional and hydration requirements.
- On Allerton Ward we saw one patient who had been started on the end of life care pathway following discussion with the patient's family earlier in the day. Nursing staff told us the patient was 'nil by mouth' because there had been a possibility of surgery. Once the patient had been identified as being in the last days of life, we asked if the patient was still nil by mouth; nursing staff did not know. We were told that the

patient's intravenous fluids had been discontinued but there was no record of a hydration or nutritional assessment being carried out as part of the end of life care pathway.

- As part of the end of life care pathway, the assessment of a patient's nutrition and hydration needs was incorporated into a section titled 'additional information'. There were inconsistencies in how nutrition and hydration were recorded in this section and it was not always completed or signed appropriately by medical and nursing staff. This meant that it was not always possible to identify if a patient had been assessed for their nutrition and hydration needs in the last days of life, or to ascertain how consistently a patient's needs were being met.
- We reviewed draft documentation due to be implemented in January 2015 to replace the last days of life care pathway and we saw a section dedicated to nutrition and hydration. We saw that this included clear guidance for staff to offer assistance to patients who wish to eat or drink. The guidance stated that "patients may still elect to eat and drink, despite the risk of aspiration, provided the patient is able to understand the risks. In the case of a patient who does not have mental capacity to be able to understand the risks, then eating/drinking should be based on a best interest decision".

Patient outcomes

- The trust also participated in the 2013 National Care of the Dying Audit. The trust performed well in areas such as multidisciplinary recognition that the patient was dying and discussions with the patient and their relatives regarding this. We saw that the trust had addressed areas highlighted, such as the assessment of nutrition and hydration, as part of their review and revision of end of life care guidance.
- We viewed a change action report as a result of the audit. Examples of action taken included the provision of education around medication prescribed for the five common symptoms at the end of life, and incorporating a more robust approach to nutrition and hydration requirements in the new end of life care guidance and documentation.

Competent staff

- As part of a trust-wide specialist palliative care structure, we saw that a community specialist palliative care nurse also provided an in-reach palliative care service to patients at the Friarage Hospital. The specialist nurse providing this service worked as part of a multidisciplinary team that operated across both acute hospital sites and the community.
- We were told that the in-reach specialist palliative care nurse had more than 10 years palliative care experience and was a nurse prescriber.
- The end of life lead nurse we spoke with told us that nurses within the team were encouraged to achieve academically and received regular appraisals and supervision.
- Some ward-based nursing staff had been identified as end of life link workers with a particular interest in promoting good quality end of life care on the wards. We viewed the minutes from a palliative care link meeting from November 2014 and saw that the meeting was attended by ward nurses and that the agenda includes areas such as education, end of life guidance updates and medication.
- When we spoke with the end of life lead nurse, we were told that there were difficulties in releasing nursing staff from the wards to attend non-mandatory training. They said that, where possible, the clinical nurse specialists would deliver micro-teaching sessions on the wards where this was useful. We did not see records of micro-teaching sessions and we were told that these were done on an informal basis; however, we saw posters on the walls in some ward areas about training available on the new end of life care guidance and care plans.
- We saw, from minutes of both the palliative care link meeting and a specialist palliative care directorate meeting, that one of the plans to address the issue of releasing staff to attend study days included the provision of one-to-one shadowing placement with the hospital palliative care team. We saw that this had been offered to end of life care link nurses at Friarage Hospital.
- The SPCT had received, or were scheduled to receive, an appraisal before 31 March 2015.

Multidisciplinary working

- A weekly specialist palliative care meeting was held at James Cook University Hospital and included staff from Friarage Hospital, regional community teams and local hospice staff.

End of life care

- The palliative care consultant told us that the integration of a single locality multidisciplinary team had led to closer working and included quarterly education events.
- Patients known to the SPCT were discussed at the weekly multidisciplinary meeting and treatment plans developed.
- The palliative care consultant also told us that the team work closely with other multidisciplinary teams to identify people in the last year of life, including oncology and neurology patients.
- On the wards we saw that multidisciplinary discussions were held about patients' treatment and care and multidisciplinary staff members told us they worked together to promote good standards of end of life care.
- Weekly multidisciplinary meetings were carried out between hospital and community palliative care staff and daily handovers were incorporated as part of the SPCT's working time.

Seven-day services

- The SPCT was not currently staffed or funded to provide a seven-day, face-to-face service. Service was available Monday to Friday 8.30am to 4.30 pm.
- An out-of-hours consultant on-call rota was in operation, with palliative care consultants from two localities providing telephone advice. We viewed patients' medical records that included notes from the palliative care consultant reminding ward staff of the availability of the consultant on call.
- We were told that, from January 2015, there would be the introduction of a Macmillan-funded pilot for palliative care specialist nurses to be on call for telephone advice during the evenings and at weekends.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out of hours cover.

Access to information

- Risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs. Once a patient had been identified as being in the last few days of life, they were started on the last days of life care pathway which incorporated prompts for assessments of the patient's symptoms and monitoring the effectiveness of interventions.
- The pathway was used appropriately in most instances, however, we did see that assessments and evaluations were not always completed which meant that the information needed was not necessarily available in a timely way for the delivery of effective care. One example of this was a patient who had been 'nil by mouth': nursing staff told us this was due to the possibility of surgery, however, there was no record of the patient's nutritional status being reassessed as part of the decision to commence the last days of life care pathway.

Consent, Mental Capacity Act and deprivation of liberty safeguards

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- We viewed an example of a patient whose DNA CPR decision was reviewed and reinforced following discussion with the patient and their family. The doctor had recorded in the notes that the decision had been discussed and agreed with the patient and family, yet nursing staff told us that the patient did not have the mental capacity for this. There was no documented mental capacity assessment.
- DNA CPR guidance included a statement that decisions should be made in the person's best interest, following the best interests process as required by the Mental Capacity Act 2005. The trust's DNA CPR policy stated that "Healthcare documentation needs to reflect that the decision for CPR or completion of a DNA CPR has been made in adherence to the best interest principle of the Mental Capacity Act (2005). Completion of the trust capacity assessment documentation will provide this required documentation".
- While there were references to decisions being made in a patient's best interest, it was not clear what process had been followed in the absence of a clear mental capacity assessment.
- We viewed an example of a trust-wide audit (July 2014) of DNA CPR forms that identified issues such as recording of discussions with the patient or relatives and ensuring that the DNA CPR form was correctly completed. We did not see evidence that the appropriate completion of mental capacity assessments was included as part of the audit undertaken.

End of life care

Are end of life care services caring?

Good

We observed patients being cared for with dignity and respect. Staff were seen to be compassionate and caring and we saw examples of staff involving patients and their families in their care. Patients we spoke with told us that staff were caring and they felt that the quality of care they received was of a high standard.

Patients felt involved in decisions about their care and relatives felt that staff were kind and caring. We saw that relatives could stay with people in the last days of life and a dedicated space and bathroom facilities were available for relatives to rest and use.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- Patients and relatives we spoke with were positive about the way they were supported with their care requirements. One patient told us, "the care is very good. They look after me well".
- We were told that, where possible, patients in the last days of life would be nursed in a side room and that visiting times were flexible to accommodate family members. There were accommodation and bathroom facilities on-site for visitors to stay with a relative at the end of life.
- The results of a bereaved relative survey from July 2014 showed that discussion with family members about the commencement of the last days of life care pathway was very positive. There were also positive responses about the compassion shown to patients, the level of bereavement support and information given to family members.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care. One patient told us, "I feel involved in decisions about my care, the staff listen to what I want".
- We observed nursing staff speaking with patients and relatives about care and treatment plans so that they could understand and be involved in decisions being made. We saw that the family of one patient, who had been identified as being in the last days of life, had met with the medical staff to discuss their care.
- We viewed records in patients' notes that included details of discussions with patients and their relatives around their care and treatment options.
- We saw that, when a patient's condition had deteriorated, staff included family members in discussions about care in the last days of life.
- Information was provided to patients and their relatives in various formats, including face-to-face discussions with medical and nursing staff and other members of the multidisciplinary team.
- We viewed information leaflets available to people following bereavement that included registering the death, referrals to the coroner and arranging the funeral.
- We viewed an information leaflet for families around what to tell children in the event of bereavement. This included information on emotional responses, the process of loss and grief and local support services available.
- The trust's website included useful links for patients and carers relating to palliative and end of life care, including support groups and information services relating to specific conditions, as well as details of local hospices.

Emotional support

- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their relatives.
- We observed instances where emotional support was given to patients and those close to them. For example, we saw support being given to a patient who had been taken ill while on holiday. When the patient's condition deteriorated, we saw that the staff demonstrated a good understanding of the issues the patient and their family faced and treated them with compassion in all observed interactions.
- The specialist palliative care nurses provided additional support, including emotional support, to patients and their families as part of ongoing end of life care input.
- Chaplaincy staff were visible within the hospital and there were prompts available as part of the last days of life guidance documents to ask patients and relatives if they would like support from the chaplaincy.

End of life care

- Multi-faith chaplaincy support was available and could be accessed as required. Support available included counselling and pastoral care as well as support for the bereaved that included the provision of memorial services.
- There was good access to psychological services. For example, patients could be referred to the Intensive Home Treatment Team (IHTT) in the community who provided support around psychological assessment and intervention for patients to reduce the length of hospital admission for those experiencing psychological crisis.

Are end of life care services responsive?

Good

All patients requiring end of life care could have access to the SPCT. Hospital referrals to the service for 2013/14 totalled 95, an increase of almost 20% from the previous year. Ward staff we spoke with told us the SPCT responded quickly to requests for support and we viewed evidence of the team's continuing input in our review of patient records.

Out-of-hours specialist palliative care input was of a good standard, with a palliative care consultant on call for advice 24 hours a day. There were also plans to pilot a specialist nurse on-call system from January 2015. We saw evidence of systems to discharge patients home quickly when home had been identified as their preferred place of care at the end of life.

Service planning and delivery to meet the needs of local people

- The hospital-based SPCT worked closely with community, hospice and other regional partners to ensure that support was available to ward-based staff and patients 24 hours a day.
- The SPCT provided support to facilitate rapid discharge home for patients who wished to die at home. We saw one example of a patient who was discharged home within 48 hours of making the decision and another where the multidisciplinary team worked closely together to get the patient home as per their wishes.
- We were told that a fast-track information pack had been produced to facilitate smoother discharge of patients who were at the end of life, from Friarage Hospital to their preferred place of care.
- Staff on the wards told us that they were able to discharge patients quickly once a decision had been made and that support was available from the SPCT to facilitate this.
- A non-executive director had been nominated as the lead for end of life care from September 2014.
- Timely identification of patients who may die in the next 12 months had been incorporated into the work plan of the end of life steering group. Members of the SPCT told us this was a priority area in terms of the future care planning process.
- The specialist palliative care consultant told us of a pilot that had been carried out over a six-month period to better identify patients in the community. Multidisciplinary teamswould highlight people admitted into hospital and link them with the SPCT sooner.

Meeting people's individual needs

- Staff on the wards told us that all patients identified as being at the end of life would be seen by the specialist palliative care nurse for additional support as required.
- Translation services were available and accessible when needed.
- Support was available for people living with dementia. There was a dementia nurse specialist within the trust and dementia training was available to all staff. We also saw that the 'This is me' booklet was used within the hospital to help staff better understand the needs of individual patients with dementia.
- There was a learning disability specialist nurse available within the trust to support the individual needs of patients and provide advice and information to staff.
- Patients and family members we spoke with told us that their care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- Mortuary and bereavement staff told us they had access to information about different cultural, religious and spiritual diversities and that they were able to respond to the individual needs of patients and their relatives.

Access and flow

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End of life care

- Staff on the wards told us that the SPCT were responsive to patients' needs and, following referrals, most patients would be seen by a member of the team within a couple of hours.
- A referral process was developed to raise the profile of the SPCT and to promote appropriate referrals. We were told that a copy of the algorithm was distributed to wards at Friarage Hospital and we saw it displayed on the wall of one of the wards we visited.
- An audit of the preferred place of death from April to October 2014 showed that, of the 143 deaths included in the audit, 79 were expected and the patient was on the last days of life care pathway. Of the 79 patients, 53 (67%) had their preferred place of death recorded on the pathway with 49 (92%) achieving their preferred place of death.

Learning from complaints and concerns

- Staff told us that complaints were handled in line with the trust policy. We did not see records of any complaints relating specifically to end of life care at Friarage Hospital, although we did see five trust-related records of complaints specific to end of life care.
- The specialist palliative care consultant told us the SPCT would be informed of complaints specific to end of life care and would participate in a review to inform future learning. We were also told that specific failings and actions from substantiated complaints would be reported to the quality assurance committee, the patient experience sub-group and the hospital board.
- The SPCT were represented as part of trust-wide mortality and morbidity meetings so that all deaths were reviewed with specialist input.

Are end of life care services well-led?

Good

Leadership of the SPCT was good, with evidence of strategic and operational leadership in terms of both development and delivery of the service. We saw evidence of good team working and cross-organisational relationships, including excellent partnership working across acute, community and hospice services. Key themes had been identified by the trust and these had been incorporated into an action plan led by an end of life steering group that had representation at board and patient/carer level.

There was evidence of good leadership at ward level and an understanding of the importance of good quality end of life care among frontline staff. An area to be developed further is the approach to end of life care education for frontline staff. While we saw a commitment to this from the SPCT, further action is needed to ensure a robust and consistent approach to equip frontline staff to care for people at the end of life. Innovation activities included the implementation of a fast-track information pack for people being discharged to their preferred place of death, the use of a referral algorithm to improve understanding of when to refer patients to the SPCT and the implementation of palliative care link meetings for ward-based nursing staff.

Vision and strategy for this service

- The trust had established an end of life steering group from September 2014 and had developed a work programme with identified themes, including the provision of care in the last year of life, evaluation, education, staff support and board engagement and assurance.
- We met with the non-executive director with nominated responsibility for end of life care and heard from members of the steering group that work had begun to ensure that good quality end of life care was part of the core business of the trust.
- We were told that one of the key themes was to drive education and training on end of life care. It was acknowledged that there were issues with ward staff attending relevant training due to pressures on their time. Strategies planned to promote end of life care education included agreeing mandatory training in some aspects of end of life care, including the use of e-learning resources and the provision of nutrition and hydration in end of life care education.
- Strategies proposed to provide support for staff delivering end of life care was to establish regular drop-in support and reflection sessions, and to undertake a scoping exercise to establish both formal and informal support arrangements on the wards.

Governance, risk management and quality measurement

End of life care

- Specialist palliative care reports within the structure of specialty medicine. As part of the trust's organisational restructure in April 2014, the Hambleton and Richmondshire SPCT has become part of the integrated palliative care team within the specialty medicine centre. In-reach specialist palliative care nursing support at the Friarage Hospital was provided by this team.
- We viewed a specialist palliative care directorate structure that reported through to the managing director, head of nursing and chief of service for specialty medicine.
- We viewed minutes from specialist palliative care directorate meetings and saw that these were attended by members of the directorate, including the directorate manager, nurse consultant and clinical director.
- Complaints, incidents, audits and patient experiences were reviewed and action was taken as a result.
- We saw from the end of life work programme and the change action report from the National Care of the Dying Audit that there were action plans to further develop and improve the end of life care service across the trust.
- There was strong leadership of the SPCT, led by the palliative care consultant and the end of life lead nurse. At Friarage Hospital, a specialist palliative care community nurse specialist provided good local leadership and specialist input for patients and staff.
- Engagement between the SPCT and ward-based staff was good and we saw evidence of good quality end of life care being promoted throughout the hospital.
- We were told that the SPCT was visible on the wards and that they were accessible and responsive to the needs of patients and the support needs of staff working on the wards.
- The SPCT had completed good work in raising the awareness of phasing out the Liverpool Care Pathway and on the development of new guidance, with training sessions advertised on wards and staff attending micro-training sessions on their own wards.
- Not all nursing staff we spoke with were familiar with how the guidance and documentation for end of life care was changing, however, we saw plans recorded as part of ongoing work to monitor closely the implementation of the new guidance.
- There was evidence of Trust Board involvement in end of life care through representation at end of life steering group meetings. We saw that action had been taken to ensure the end of life steering group included patient/carer representation.
- We viewed an example of how patient experiences were presented to the Trust Board to ensure learning, transparency and momentum for continued improvement of services for patients and their relatives.

Culture within the service

- Staff spoke positively about the quality of care they felt able to provide for patients at the end of life. There was positive feedback from ward staff about the support and input they received from the SPCT.
- Staff in A&E told us they had identified a learning need around end of life care and that the specialist palliative care clinical nurse specialist was supporting them around this. We viewed an annual activity report from the Hambleton and Richmondshire locality SPCT that showed eight A&E nurses had attended palliative care awareness training in the last year.
- It was clear from our conversations with staff that there was commitment to provide the best care possible to people at the end of life. Relatives we spoke with told us they found the approach of staff from different work areas to be consistently supportive and committed to good quality care.
- As part of the development of good quality end of life care services within the trust, there was a strategic intent to further develop a culture of learning and education to improve end of life care services.

Public and staff engagement

- A bereavement survey was in place to ensure ongoing feedback from relatives to provide information on the experience of patients and ensure good care, with areas identified for improvement.
- The trust was participating in a 'Family's voice' research study where friends and relatives were asked to complete a daily diary of their experience, including information about comfort and support given in the last days of life. The aim of the study was to give family and friends a voice and provide feedback to staff and the SPCT.
- The trust had appointed a patient/carer representative to the end of life steering group.

End of life care

Innovation, improvement and sustainability

- The SPCT used national guidance and tools to develop the service.
- While there was evidence of the use of the Liverpool Care Pathway at the time of our inspection, the SPCT acknowledged there had been delays in developing the new guidance to replace it. We saw that new guidance/ documentation had been piloted and feedback from ward-based staff had been used to streamline and improve the documentation with a start date of early January 2015.
- Training sessions had been scheduled for staff to attend and there was a good level of knowledge among ward staff that the new guidance was being implemented.
- A pilot study to improve access and referral to the SPCT been evaluated. There were plans to further develop this work in the coming year with a view to improving patient outcomes.
- A pilot of a specialist nurse on-call system was due to commence in early 2015 following a successful bid for funding from Macmillan. The aim of this pilot was to improve advice and support to patients at the end of life in hospital and in the community.
- Difficulties in recruiting a second palliative care consultant had been addressed by appointing a half-time respiratory consultant with a special interest in palliative care in order to improve the level of medical input to the palliative care team.
- Plans were in place to create work-shadowing placements for ward-based nursing staff to work with the SPCT as an approach to improving ward nurses' knowledge and skills in caring for patients at the end of life.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Friarage outpatients and diagnostic imaging departments were situated on the main Friarage site in Northallerton. There was a total of 124,971 outpatient appointments between April 2013 and March 2014. The ratio of new appointments to review appointments was around 1:3.

Outpatient clinics were held in two different locations on the site: the main outpatients; and the Scott Suite. Within the main outpatients department, there were 20 consulting rooms. The outpatients department ran a wide range of clinics, some nurse-led, some led by allied healthcare professionals and some by doctors across a large number of specialties such as urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ear, nose and throat (ENT), respiratory medicine and neurology. The imaging services were conducted from one location on the site and provided general radiography, computerised tomography (CT) scans, breast imaging, ultrasound scanning and fluoroscopy.

During the inspection, we spoke with 10 patients and three relatives, two department managers, one nurse, three doctors, a sonographer, seven radiographer's, one x-ray porter and three healthcare assistants. We observed the radiology and outpatient environments, checked equipment and looked at patient information.

Summary of findings

Overall, the care and treatment received by patients in the Friarage outpatient and imaging departments was effective, caring, responsive and well-led. There were some areas of improvement, particularly in safety. We found that some checks on equipment had not been carried out regularly. Additionally, in the imaging department, we found that medication stored in the drug fridge was not regularly checked to ensure that medicines were stored within the appropriate temperature parameters.

Within the outpatients department, there were concerns that the low number of registered nurses meant that the skills mix of staff was not always able to support patients' needs.

Patients were very happy with the care they received and found it to be caring and compassionate. Staff were supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because there were policies to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

A number of patient information leaflets across the departments were past their review dates and there was no evidence that patient satisfaction surveys were completed specifically in relation to outpatients.

Outpatients and diagnostic imaging

Services offered were delivered in an innovative way to respond to patients' needs and ensure that the departments work effectively and efficiently.

Are outpatient and diagnostic imaging services safe?

Requires improvement

The level of care and treatment delivered by the outpatient and imaging services required improvement. We found that some checks on equipment had not been carried out regularly. Additionally, in the imaging department, we found that medication stored in the drug fridge was not regularly checked to ensure that medicines were stored within the appropriate temperature parameters.

There were concerns within the outpatient department that the skills mix of staff was not always appropriate to support patients' needs. Staffing levels were based on historic knowledge and not on any formula, therefore there was risk that there were not enough skilled staff employed or deployed by the department.

Incidents were reported using an electronic reporting system, but only after the department's manager decided that the incident was reportable. This meant that staff did not report incidents independently. Incidents were investigated and lessons learned were shared with all staff. The cleanliness and hygiene in the department was within acceptable standards. Staff reported that sometimes there were problems accessing sufficient personal protective equipment due to delays in the authorisation process to procure supplies. There were occasions when the outpatients department had to borrow equipment from another team until supplies arrived. This was not an issue in the imaging department. There was sufficient clean and well-maintained equipment to ensure that patients received the treatment they needed in a safe way.

Staff were aware of the various policies in place to protect vulnerable adults or those with additional support needs, and patients were asked for their consent before care and treatment was given. Staff were not always clear about who could make a decision on behalf of patients when they lacked or had fluctuating capacity.

Medical records were available for outpatient clinics with very few exceptions. We observed that, in the outpatients

department, staff sometimes left medical records and clinic lists containing personal patient information unattended in places that could be accessed by members of the general public.

Staff in all departments were aware of the actions they should take in the case of a major incident.

Incidents

- There had been one serious incident reported by the outpatient department at the Friarage Hospital.
- There were eight reported radiation incidents across the trust. Information provided by the trust did not grade these incidents and the information was not available by site. Clear actions had been taken to address these incidents within the imaging departments.
- Of the eight incidents, six had been reported to the CQC under the Ionising Radiation (Medical Exposure) Regulations – IR(M)ER.
- The trust used an electronic system to record incidents and near misses. All staff who work in the departments were able to access the system to record incidents.
- Staff only reported incidents after agreement from their manager. This meant that staff were not independently reporting incidents.
- We spoke with three staff about their knowledge of the incident reporting system. All staff said they could access the system and knew how to report incidents.
- Staff were able to give examples of reported incidents and changes in practice that had resulted from the subsequent investigations.
- Staff were aware of their responsibilities in terms of the Duty of Candour regulation introduced in November 2014.
- The departments had robust systems to report and learn from incidents, and to reduce the risk of harm to patients.

Cleanliness, infection control and hygiene

- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Personal protective equipment such as rubber gloves, protective eye glasses and aprons, were available to staff.
- Once used, protective equipment was disposed of safely and appropriately.
- The imaging department, outpatient areas and clinic rooms were clean and tidy and we saw staff maintaining the hygiene of the areas using appropriate wipes to clean equipment between patient use, thus reducing the risk of cross-infection or contamination between patients.
- The imaging and outpatients department staff took part in regular hand-washing and environment audits. We saw the latest reports which showed high levels of compliance .

Environment and equipment

- The environments of the outpatient departments were well-lit, although the waiting areas sometimes had no natural light.
- During our inspection, we saw that the waiting rooms got busy. Staff told us that sometimes there was not sufficient seating for patients in the waiting areas, particularly if clinics were running late. There were occasions when patients had to stand.
- Overall, the outpatient departments were not large enough to meet the needs of all patients, particularly during busy times and if there were people with wheelchairs. This is based on our observations and information given to us by staff and patients.
- We saw, and staff confirmed, that there was sufficient equipment to meet patients' needs in the outpatient and imaging departments. We looked at resuscitation equipment in both departments: it had been checked regularly as required within the outpatients department, however, within the imaging department, this was not the case. The resuscitation equipment had not been regularly checked in accordance with the trust's policies. This was reported to the department manager who took immediate action to rectify the situation.
- Equipment was cleaned regularly and serviced in line with manufacturer guidance. Staff showed us how they cleaned equipment. The equipment we looked at was clean.
- There were maintenance contracts to make sure that equipment was serviced and kept in good working order and any faulty equipment was repaired in a timely manner.
- The departments were able to replace broken equipment promptly and able to order new equipment if it was clinically needed. Staff we spoke with confirmed this.

Outpatients and diagnostic imaging

- A review of the imaging departments by the Radiation Protection Adviser (RPA) in November 2014 identified no concerns about the environment and equipment in the imaging departments across the trust.
- During our observations we saw that there was clear and appropriate signage regarding hazards in the imaging department.

Medicines

- The outpatients department kept a limited supply of medication. It was stored in locked areas, cupboards and trolleys, and kept at the right temperature. Patients who needed medication such as insulin were asked to bring their own supply when they visited the outpatients department. Doctors prescribed any additional medication needed.
- We found that the medication stored in the drugs fridge within the imaging department fridge did not have its temperature checked daily and, therefore, it could not be determined that medication had been stored at the appropriate temperatures. We brought this to the attention of the department manager who immediately reported the incident and rectified the situation.

Records

- Records in the outpatients department were paper-based. Within the imaging department, records were digitised and available to be viewed across the trust.
- Records contained patient-specific information relating to the patients' previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- Between the two sites, there had been 17 instances recorded on the Datix system relating to medical records not being available for clinics in outpatient departments. The information was not available for individual sites. Records were either lost, unavailable or delayed in all cases. Staff, however, told us that they did not always report missing patient records as an incident.
- Information sent to us by the trust showed that, between April and October 2014, the percentage of notes available for outpatient clinics was consistently above 99.8%.
- Staff told us that they were able to access some information about patients using the electronic recording system where some clinic letters were held, although they were not able to access letters relating to the patient from other departments. Staff all agreed that a patient would always been seen as long as there was some information about them available.
- Within the radiology department, patients' imaging records and reports were securely available for staff to access electronically.
- During our observations within the outpatients department, we saw an occasion when medical records were left unattended and unsecured. This was brought to the attention of the manager who immediately moved the records to a secure location.
- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatients department. We observed people being weighed and measured during our inspection.

Safeguarding

- Information provided by the outpatient manager indicated that only 12.5% of staff had completed safeguarding children level 1 training and 38.9% of staff had completed the level two training. The manager agreed that these figures were low and needed to improve. They had arranged for staff to attend training based in the department, wherever this was possible, to address the issue.
- Safeguarding adults level 1 training had been completed by 73.1% of staff.
- Safeguarding Adults level one had been completed by 77% of diagnostic imaging staff. Safeguarding children level one had been completed by 92% of staff and safeguarding children level two had been completed by 92% of staff. Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.

Mandatory training

- The departments had systems and processes in place to ensure that staff training was monitored.
- We looked at staff mandatory training levels provided to us by the outpatients department manager. There were 14 different types of mandatory training. We saw that, on the whole, the outpatient departments were rated

'green' for 10 of these: equality and diversity (61.5%); paediatric basic life support (64.7%); patient safety (66.7%); health and safety (69.2%); safeguarding adults level 1(73.1%); fire safety (84.2%); the Mental Capacity Act 2005 (86.7%); basic life support (88.9%); information governance (92.3%); and moving and handling (94.1%).

- The outpatients department was rated 'amber' for infection prevention and control level 1 (53.6%) and level 2 (55.6%) training attendance.
- The outpatients department was rated 'red' for safeguarding children level 1 (12.5%) and level 2 (38.9%).
- Where staff training levels were low, action was taken to help improve them – for example, by asking trainers to attend the department to deliver training sessions, rather than staff having to leave the department to attend.
- We looked at mandatory training levels provided to us for the imaging department. These showed compliance levels for consent, 77%, fire safety, 73%, hand hygiene, 59%, health and safety, 82%, infection prevention and control, 52%, information governance, 100%, mental capacity act. 73% and slips, trips and falls, 93%.

Assessing and responding to patient risk

- There was a process for managing patients who were deteriorating. This included transferring patients to the on-site A&E department when required.
- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms and imaging. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- There were policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances was managed and minimised.
- The RPA report highlighted that all new equipment had been risk-assessed to ensure the safety of staff and patients.

Nursing and diagnostic imaging staffing

- The outpatients department was staffed by a mixture of registered nurses and healthcare assistants. At the time of our inspection, the department had one 0. 8 whole time equivalent (WTE) manager, 2.1 WTE registered nurses (one of whom was on long-term sick leave), 14 band 2 healthcare assistants, two band 3 healthcare assistants, one band 1 healthcare assistant and 0.8 WTE plaster technicians.
- Staff told us that the number of registered nurses had reduced due to staff leaving. Replacements were being recruited, but these were not registered nurses. Replacement staff were healthcare assistants. The manager told us this meant that sometimes it was difficult to ensure the skills mix in the clinic was right. The manager explained that the problem had been escalated to their senior manager but, because of financial constraints, all new staff were of lower grades. From our discussions, patients were unaware of any problems. On occasions when there was a possible impact on patients, these were not reported on the incident reporting system. The manager explained that the nurses currently employed covered clinics but that this was a stressful situation due to anticipated maternity leave.
- We asked the manager whether they were able to access agency or bank (overtime) staff to fill any gaps, or if staff went on long-term sick leave or maternity leave. They told us they could not use bank or agency staff due to financial constraints and had to make the best of the staff they had. Where possible, staff worked flexibly to cover shifts.
- The sickness rate in the outpatients department was at 7%, one of the highest in the trust.
- Staff told us that they worked hard, but that stress levels were high and morale was low. The senior manager was aware of this, however, staff felt that little action was being taken to improve the situation.
- There was no formal system, such as an acuity tool, being used to decide the staffing levels needed in the outpatients department to cover clinics. Staffing levels and skills mix were baesd on historic levels. This meant that there was no formal way of making sure that the correct number or skills mix of staff was present at any one time.
- Within the imaging department there were no issues with staff shortages or skills mix. There were 14.8 WTE radiographers employed and 4.2 WTE healthcare assistants. There were currently two radiographer vacancies which were being recruited to.

Medical staffing

- Medical staffing was provided to the outpatients department by the various specialties which ran clinics.

Outpatients and diagnostic imaging

Medical staff undertaking clinics were of all grades, however, we saw that there were always consultants available to support lower-grade staff when clinics were running.
- Staff told us that there was only limited use of locums within the outpatient clinics.
- Within the imaging department, some radiologists worked specifically at the Friarage, while others worked across the trust, providing the required radiological cover for each site. There was sufficient medical staff cover to meet patients' needs.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident.
- There were business continuity plans in place to make sure that specific departments were able to continue to provide the best possible safest service in the case of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Care and treatment provided by the outpatient and diagnostic imaging departments was evidence-based and patient outcomes were within acceptable limits. The staff in the departments were competent and there was evidence of multidisciplinary working.

Evidence-based care and treatment

- We saw that National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments, with a lead clinician taking responsibility for ensuring implementation. Staff we spoke with were aware of NICE and other guidance that affected their practice.
- We saw that the departments were adhering to local policies and procedures. Staff we spoke with were aware of how they impacted on patient care.
- The trust has a standard operating procedure in place for (IR(M)ER).
- The imaging department carried out quality control checks on images to ensure that imaging met expected standards.

Pain relief

- Staff told us that the departments did not keep pain relief medication but that the doctors in clinic could prescribe this medication for any patient who needed it.
- Patients we spoke with had not needed pain relief during their attendance at the outpatients department.

Patient outcomes

- In the last 12 months, the outpatients department saw 124,971 patients.
- Of these, 34,992 were new appointments and 82,481 were review appointments.
- All images were quality-checked by radiographers before the patient left the department. National audits and quality standards were followed in relation to radiology activity.
- The outpatients department took part in trust-wide audits, such as record-keeping, but there was little clinical audit initiated by and carried out within the department.
- We saw evidence of clinical audits being carried out by the imaging department, such as reducing the risk to patients undergoing intravenously enhanced CT scans and adherence to Royal College of Radiologists' standards of practice.

Competent staff

- Staff confirmed that they had received appraisals in the last year. From information provided by the trust, 92% of staff had received an appraisal.
- Staff told us that they did not receive formal clinical supervision as per the trust policy, but that they felt supported and that the department managers were accessible.
- In both the outpatient and imaging departments, there were formal arrangements for induction of new staff. All staff completed full local induction and training before commencing their role.
- In both the outpatient and imaging departments, performance and practice was continually assessed through appraisal.
- All qualified radiographers completed equipment competencies. Continuing professional development was planned by the manager on an annual basis to ensure that all statutory and topical subjects were covered.

Outpatients and diagnostic imaging

- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatient and imaging departments. For example, nurses and medical staff ran joint clinics and staff communicated with other departments, such as radiology and community staff, when this was in the interest of patients.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the department had links with other departments and organisations involved in patient journeys, such as GPs and support services.
- A range of clinical and non-clinical staff worked within the outpatients department and they told us they all worked well together as a team. Staff were observed working in partnership with a range of staff from other teams and disciplines, including radiographers, physiotherapists, nurses, booking staff, and consultant surgeons.
- Staff were seen to be working towards common goals, asking questions and supporting each other to provide the best care and experience for the patient.

Seven-day services

- The outpatients department occasionally ran clinics on a weekend; however, most activity within the department happened between Monday and Friday.
- The imaging department provided general radiography, CT scans, breast imaging, ultrasound scanning and fluoroscopy services for both outpatients and inpatients every day. There was a rota to cover evenings and weekends. This made sure that patients were able to access diagnostic radiology when they needed to.

Access to information

- All staff had access to the trust's intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information, such as imaging records and reports, medical records and physiotherapy records, through electronic and paper records.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff we spoke with were aware of how to obtain consent from patients. They were able to describe to us the various ways they would obtain consent from patients. Staff told us that in the outpatients department, consent was obtained verbally. This was the case for the majority of imaging procedures, although consent for any interventional radiology was obtained in writing on the ward prior to attending the imaging department.
- The hospital had specific paperwork for adults who are unable to consent to investigation or treatment which included sections about assessing people's capacity, best interests and involvement of the family and carers. Some of the staff we spoke with in the outpatients department were unsure about the action to take if a patient had fluctuating capacity and they were unsure who could legally make decisions on behalf of a the person. Around 50% of staff were up to date with Mental Capacity Act (2005) training. Plans had been made by the manager to hold training sessions within the department to address this.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good

During the inspection we saw, and were told by patients, that the staff working in the outpatient and imaging departments were caring and compassionate at every stage of their journey. People were treated respectfully and their privacy was maintained. There were services in place to emotionally support patients and their families. Patients were kept up to date and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

Compassionate care

Outpatients and diagnostic imaging

- All of the patients we spoke with spoke highly of the care and treatment they received in the departments. There were no negative aspects highlighted to us. People told us they preferred to come to the Friarage Hospital rather than other hospitals because it had a "homely feel".
- During our inspection, we saw patients being treated respectfully by all staff.
- People's privacy and dignity were respected. Some of the areas where patients were weighed were in the open waiting room, however, staff had made sure that the scales were in the corner, as much out of the public eyesight as possible.
- Staff made sure that patients were kept up to date with waiting times in clinic.
- We saw that patients and staff had a very good rapport, especially as many patients had been attending clinics for a number of years. Some patients told us that they knew staff so well, they felt like "family". Some staff told us the same about patients.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas.

Understanding and involvement of patients and those close to them

- We spoke with 15 patients and their relatives in the outpatient and imaging departments. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Patients felt that they received clear information and were given time to think about any decisions they had to make about different treatment options. They also told us that the treatment options had been explained to them clearly, with enough information about side effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care, however, they respected the decision of patients when they chose not to involve others.

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that, if they had any concerns, they were give the time to ask questions. Staff made sure that people understood any information given to them before they left the departments.
- Formal and informal networks had been created by staff to link patients with people with similar conditions who were further along their patient journey. There were posters on the walls promoting these groups, for example, for patients with cancer.
- There was formal counselling support available for patients who needed it.

Are outpatient and diagnostic imaging services responsive?

Good

We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Waiting times were within acceptable timescales, with outpatient clinics only occasionally being cancelled. Patients were able to be seen quickly for urgent appointments if required.

There were mechanisms in place to ensure that the services were able to meet people's individual needs, such as support with living with dementia, a learning or physical disability or those whose first language was not English. There were also systems to report concerns and complaints raised within the departments, to review these and take action to improve the patients' experience.

Service planning and delivery to meet the needs of local people

- Staff were supported by colleagues within the wider department at busy times, or when there were absences. This made sure that clinics were only cancelled as a last resort.
- Occasionally additional outpatient clinics were run to meet extra demand to ensure that waiting time targets were met. However, this did not happen regularly due to staffing issues.
- The treatment rooms in the department could be used flexibly and were shared between the various outpatient clinics which ran on the site.
- The department was busy and staff told us that space was always at a premium.
- The imaging department was able to provide a comprehensive service across the community, in local community hospitals as well as at the Friarage Hospital.

Outpatients and diagnostic imaging

- The imaging department had the capacity to deal with urgent referrals.

Access and flow

- For patients not admitted, 99% were seen within 18 weeks of referral. This was consistently better than the standard of 95% and better than the England average.
- The average referral-to-treatment times for the Friarage ranged from 97% in June 2014 to 95% in November 2014.
- The trust performed better than the England average and the operation standard of 92% for patients starting consultant-led treatment, but with incomplete pathways of care.
- The trust was performing in line with the England average for patients with all cancers being seen urgently within two weeks.
- The trust was performing better than the England average for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers.
- The trust did not routinely collect information about the average waiting time for patients once they arrived at an outpatients clinic and before being called in to their appointment.
- The rates for patients not attending appointments in the outpatients department between August and October 2014 varied between 5.38% and 6.7% for new appointments and between 6.2% and 8.8% for review appointments. The manager told us that work was underway to try to reduce these rates.
- Staff told us that there was always capacity in clinics to see patients who were referred urgently and that double-booking two patients in to one clinic slot only happened occasionally to make sure that waiting time targets were met. Information about how often this happened was not routinely collected by the trust and therefore is not quantifiable. We spoke with one patient who told us that they had been referred urgently and had been seen within 10 days.
- Within the diagnostics department, the trust was performing better than the England average for patients waiting more than six weeks for a diagnostic test. Although still better than the England average, the percentage had increased from 0.2% in April 2013 to 2.1 in April 2014. By July 2014, the rate had improved to 1.6%.
- In the imaging department, GP referrals were reported within five days, ultrasounds reported immediately, inpatient CT scans within one day and outpatient CT scans within four days.

Meeting people's individual needs

- Staff told us that they were able to access interpreting services if they needed to. Staff told us that there was very little demand for interpreters at the Friarage Hospital.
- We saw that the outpatient and imaging departments had information leaflets for patients, however, we noted that some of these leaflets were past their review date, some by a number of years. Leaflets were available in different languages on request.
- Staff told us that, when patients with learning disabilities attended the department, wherever possible the patient was seen as a priority. Staff were also aware of the support that was available within the trust and were aware to allow carers to remain with the patient if this was what the patient wished.
- Staff told us they were aware of how to support people living with dementia. They told us that most patients living with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly.
- There was a canteen available for patients to use and the department had access to food and drinks for vulnerable patients or those who had conditions such as diabetes. There was a system in place to make sure that patients who had attended by wheelchair and were waiting to return home were also able to access food and drinks.
- On the whole, the department was able to accommodate patients in wheelchairs or who needed specialist equipment, although some waiting areas could become overcrowded if more than one wheelchair patient attended at the same time.
- In the therapy CT department, CT scanning staff had made simple changes to the environment and recognised the need for additional patient support during CT scanning. They had linked with the holistic care centre to offer massage and other complementary therapies, along with providing a calm environment to wait in preparation for a CT scan.

Learning from complaints and concerns

Outpatients and diagnostic imaging

- There were seven complaints about the outpatients department raised between December 2013 and 30 November 2014. Two of these were about aspects of care and four were about delayed or cancelled appointments. One related to the communication of information to the patient.
- There were three complaints about imaging services between December 2013 and 30 November 2014. It was not possible from the information to specify which site these complaints related to. One related to attitude of staff, one to all aspects of clinical treatment and one to appointment delays or cancellations.
- Staff we spoke with were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the Patient Advice and Liaison Service, or how to make a complaint was available in waiting areas.
- Managers and staff all told us that complaints and concerns were discussed at local team meetings and any learning was shared. We looked at two sets of team meeting minutes which confirmed this.
- None of the patients we spoke with had ever wanted to, or needed to, make a formal complaint. On the whole, they were happy with the experience they received from the departments.

Are outpatient and diagnostic imaging services well-led?

Good

Within the outpatient and imaging departments of the Friarage Hospital, staff and managers had a vision for the future of the departments and were aware of the risks and challenges faced. Staff felt supported by their line managers and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. The departments were supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments.

At the time of the inspection, there was no evidence of formal proactive engagement with patients.

Vision and strategy for this service

- The department managers we spoke with demonstrated vision for the future of the outpatient and imaging services. They were aware of the challenges faced by the departments and the trust as a whole.
- Staff within the services were aware of the challenges, such as financial constraints, faced by the organisation. Most personnel told us that they were aware there was a strategy for the trust, but they were mostly interested in the future of the Friarage Hospital.

Governance, risk management and quality measurement

- There were strong governance arrangements in place which staff were aware of and participated in. The departments had regular clinical governance meetings. Staff were given feedback about incidents and lessons learned and the trust regularly produced 'lessons learned' newsletters.
- The organisation had systems in place to appraise NICE guidance and ensure that any relevant guidance was implemented in practice.
- Within the imaging department, there were examples of audits to ensure that NICE and other guidance was being adhered to. For example, an audit of trauma radiology had recently been undertaken and results and action plans were awaited. Audits of the accuracy of extended radiographer reporting and an audit of the accuracy of shoulder ultrasound versus arthroscopy had also taken place.
- Both outpatients and diagnostic imaging had risk registers in place. These were reviewed and updated regularly. We saw that action was being taken to manage, minimise or eliminate risks.
- Some of the patient information leaflets within the department were past their review dates. This showed that the trust did not have an effective system in place for ensuring that patient information was reviewed regularly and contained the most up-to-date information for patients.

Leadership of service

- Staff told us that they found the managers of the service to be approachable and supportive. All the staff we spoke with told us they were content in their role but that the department was changing as staff left and new staff started. Many staff we spoke with told us that they had worked at the hospital for many years.

Outpatients and diagnostic imaging

- One member of staff from the outpatients department told us that the department had a new senior manager who they felt was accessible, but had not visited the department since commencing in the role. They felt that the senior manager wasn't as visible as they could be.
- The manager of the department was seen as fair and flexible with staff.
- The imaging department had recently restructured its line management and reporting lines of accountability. Staff were aware of the changes and of the impact these changes were having on the service. Staff overall within the imaging department felt that the department was well-led.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust, although this was not as easy as in the past due to staffing level pressures.

Culture within the service

- Staff and managers told us that the trust had an open culture. They felt empowered to express their opinions and felt that they were listened to.
- Staff told us that the chief executive was very approachable and accessible. They were able to tell us about the different ways the chief executive communicated with staff, such as via regular a blogs, core briefings and staff bulletins.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well-supported by the organisation. Despite being located away from the main trust headquarters, all staff felt that they belonged to one organisation.
- Managers told us that members of the board occasionally visited the departments, however, this was not a regular occurrence.

Public and staff engagement

- We saw that governance arrangements were in place and complaints and comments were discussed at team meetings.
- The outpatients department manager told us that they would be taking part in the national NHS Friends and Family Test once it had been rolled-out across the trust, but that there were currently no regular satisfaction surveys being carried out by the department.
- The imaging department was currently carrying out ultrasound satisfaction surveys. This demonstrated high levels of patient satisfaction with this service.
- There was no specific information from the staff survey relating to the outpatient and imaging departments, however, the trust as a whole performed within expectations or better than expected in all but three elements of the staff survey: the percentage of staff attending health and safety training in the last 12 months; percentage of staff feeling under pressure to attend work when unwell; and staff motivation score.

Innovation, improvement and sustainability

- Staff all told us that they were being encouraged to look at ways the trust could work more efficiently, make savings and improve quality of care for patients. They told us about how they were encouraged to try changes and then evaluate them to make sure quality of care did not fall when money was saved.
- Staff and managers reported that they were able to influence changes in the way the outpatient and imaging departments were organised and run. We were given examples of changes that had been made to the way the service was run which had improved the patient experience and made the clinics run more efficiently. For example, weighing scales had been moved to a more private area to protect patient privacy and dignity.
- Of trust staff who responded to the NHS Staff Survey 2014, 66 % felt that they were able to contribute towards improvements at work. There was no specific information for the outpatient or radiology departments.

Outstanding practice and areas for improvement

Outstanding practice

- A team of therapeutic volunteers had been created which was led by a therapeutic nursing sister who had been in place for 18 months. The volunteers had mandatory and dementia training and were in operation 24hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The team had been regionally recognised for its work.
- In maternity services, the families and birth forum was involved in the design of the induction of labour suite and championing the take-up of breastfeeding rates through the use of peer supporters, as well as improving information to raise awareness and promote the service to women when they had left the hospital.
- In maternity services, lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge – a series of toolkits which are part of the productive care workstream. The toolkits help look at care in a variety of settings through the eyes of patients and service users, to help investigate what good quality care looks, sounds and feels like.

Areas for improvement

Action the hospital MUST take to improve

The trust must:

- Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, and outpatients department.
- Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are being carried out and how decisions are made.
- Ensure that there are mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatients department
- Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.
- Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.
- Ensure staff receive appropriate training and support through appraisal including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.
- Ensure that patients records are appropriately up dated and stored to ensure confidentially is maintain at all times in line with legislative requirements.
- Ensure that there are mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Ensure that resuscitation equipment and medication fridge temperatures in the diagnostic and imaging department are checked in accordance with trust policies and procedures.

Action the hospital SHOULD take to improve

In addition the trust should:

- Review College of Emergency Medicine audit data to ensure that patient outcomes are met.
- Continue to review and reduce the mortality outliers for the Hospital Standardised Mortality Ratio (HSMR).

Outstanding practice and areas for improvement

- The trust should ensure that patients who are medically fit are discharged in a timely manner to the appropriate setting to reduce the number of delayed discharges.
- The trust should ensure that medication omissions were monitored, investigated and reported in line with trust policy.
- Identify a formal board-level director who can promote children's rights and views. This role should be separate from the executive safeguarding lead for children.
- Consider the commencement of a restraint-training programme for staff in A&E.
- Incorporate the use of mental capacity assessments into the trust-wide audit of DNA CPR documentation.
- Introduce patient surveys specific to the outpatients department.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must: Ensure that resuscitation equipment in surgical wards and in outpatients and diagnostic imaging areas is checked in accordance with trust policies and procedures and that this is monitored. Ensure that there are mechanisms for reviewing and, if necessary, updating patient information, particularly in the outpatients department. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must: Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, and outpatients department. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must: Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are being carried out and how decisions are made. Ensure staff receive appropriate training and support through appraisal including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must: Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance. Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.